

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 413 MARYLAND STATE DEPARTMENT OF HEALTH  
6-9-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06995

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06991

1. DECEASED-NAME (Type or Print)		First Kenneth	Middle Alan	Last Abramson	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 5 11 69		2b. HOUR 2:58 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH 4-3-34	6. AGE (In years last birthday) 35 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 5 Day 11 Year 1969	2d. HOUR 58A M
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Liquor	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Morris Abramson		15. MOTHER'S MAIDEN NAME First Middle Last Lillian Feldstein		13e. STREET AND NUMBER 11633 Lockwood Drive			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 1957-1959		17. INFORMANT ADDRESS Rita Abramson 11633 Lockwood Dr. S.S. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute thrombosis, left Coronary artery</u> DUE TO, OR AS A CONSEQUENCE OF Coronary artery heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED May 11, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/12/69		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden, Falls Church, Va.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons 3501 14th St., N.W., Wash., D.C. 20010				25a. REC'D BY REGISTRAR MAY 14 1969		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06996 CERTIFICATE OF DEATH 06992									
1. DECEASED-NAME (Type or print) <b>Lillian W. R. Ackley</b>			2a. DATE OF DEATH Month <b>MAY</b> Day <b>3</b> Year <b>1969</b>			2b. HOUR <b>520</b> M			
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>3-8-1885</b>		6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Kensington, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Kensington Gardens 3000 McComas Ave.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>EDUCATION</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission, - STATE <b>2020 F St. N.W. Washington D.C.</b>		13c. CITY OR TOWN <b>D.C.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2020 F St., N.W.</b>			
14. FATHER'S NAME First <b>Fred</b> Middle <b>W.</b> Last <b>Chase</b>			15. MOTHER'S MAIDEN NAME First <b>Eva</b> Middle <b>Lillian</b> Last <b>Rhodes</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>532-10-3198</b>		17. INFORMANT <b>B. J. Binalley, RN - 3000 McComas Ave</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, TERMINAL</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRAIN TUMOR, RT. HEMISPHERE,</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>UNIDENTIFIED</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>5 MONTHS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>MAR. 24, 1969</b> , to <b>MAY 3, 1969</b> , that (I) (we) last saw the deceased alive on <b>MAY 2, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert G. Angle M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>MAY 3, 1969</b>			
22d. PHYSICIAN'S NAME (Type) <b>Robert G. Angle</b>				22e. ADDRESS <b>5009 Del Ray Avenue, Bethesda, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>5-5-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Prince Georges Co., MD</b>			
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SON, INC.</b> 5130 WISC. AVE., N. W. WASH., D. C. 20016				25a. REC'D BY REGISTRAR <b>MAY 8 1969</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Gaudin</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>James ARTHUR Adams</b>						2a. DATE OF DEATH <b>5</b> Month <b>18</b> Day <b>'69</b> Year			2b. HOUR <b>12<sup>05</sup> P.M.</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>7-29-89</b>		6. AGE (In years last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS <b>-</b> DAYS <b>-</b>		IF UNDER 24 HRS. HOURS <b>-</b> MIN <b>-</b>	
7a. BIRTHPLACE (State or foreign country) <b>Adams, Tenn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Potomac Valley Nursh.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Attorney-Internal</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Revenueser.</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Washington</b>				13b. COUNTY <b>D.C.</b>		13c. CITY OR TOWN <b>-</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2939 Van Ness St NW</b>	
14. FATHER'S NAME First Middle Last <b>Redding Columbus Adams</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>DORA E. Stainback</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>W.W.I. 578-56-1237</b>		17. INFORMANT <b>Mr. George E. Adams</b> Address <b>4740 Conn. Ave. N.W. Wash. DC</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Monocystic Apathetic Thromb - Hospital</b> <b>284X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 Months</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Bilateral pulmonary infarcts</b> <b>Coronary arteriosclerosis</b>											
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>65</b> , to <b>May</b> , 19 <b>69</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>17 May</b> , 19 <b>69</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.											
22b. SIGNATURE <b>C. Roger Kurtz, M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5-18-69</b>			
22d. PHYSICIAN'S NAME (Type) <b>C. Roger Kurtz, M.D.</b>				22e. ADDRESS <b>370 K Street NW Wash DC 20008</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>5/21/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>					
24. FUNERAL DIRECTOR <b>The S. H. Hines Co.</b>				ADDRESS <b>Washington, D. C.</b>		25a. REC'D BY REGISTRAR <b>MAY 21 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06998		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06994					
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR			
Elizabeth				nmm	Andes	5 Month 14 Day 69Year		11 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR			
Female		Caus.		12/15/1887		81 YRS.		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Mills, N.Y.		U.S.A.				Montgomery Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Wheaton		University Nursing Home		Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
New York				Utica				1232 Kimble Street			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
David				Allerdice		Elizabeth					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Son)		Address			
No				057-28-4415-D		David D. Andes		-4505 Romlon-Beltsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>								10 min			
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>3-28-</u> , 19 <u>67</u> , to <u>5-14-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5-14-</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Myron Lenkin</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5-14-69</u>					
22d. PHYSICIAN'S NAME (Type) <u>MYRON LENKIN</u>				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Removal		May 14, 1969		New Forest Cemetery		Utica, New York					
24. FUNERAL DIRECTOR <u>James E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>MAY 15 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>					

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CERTIFICATE OF DEATH

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 10, 11, 18 & 22a  
 Film 413 6-1-18 & 22a  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

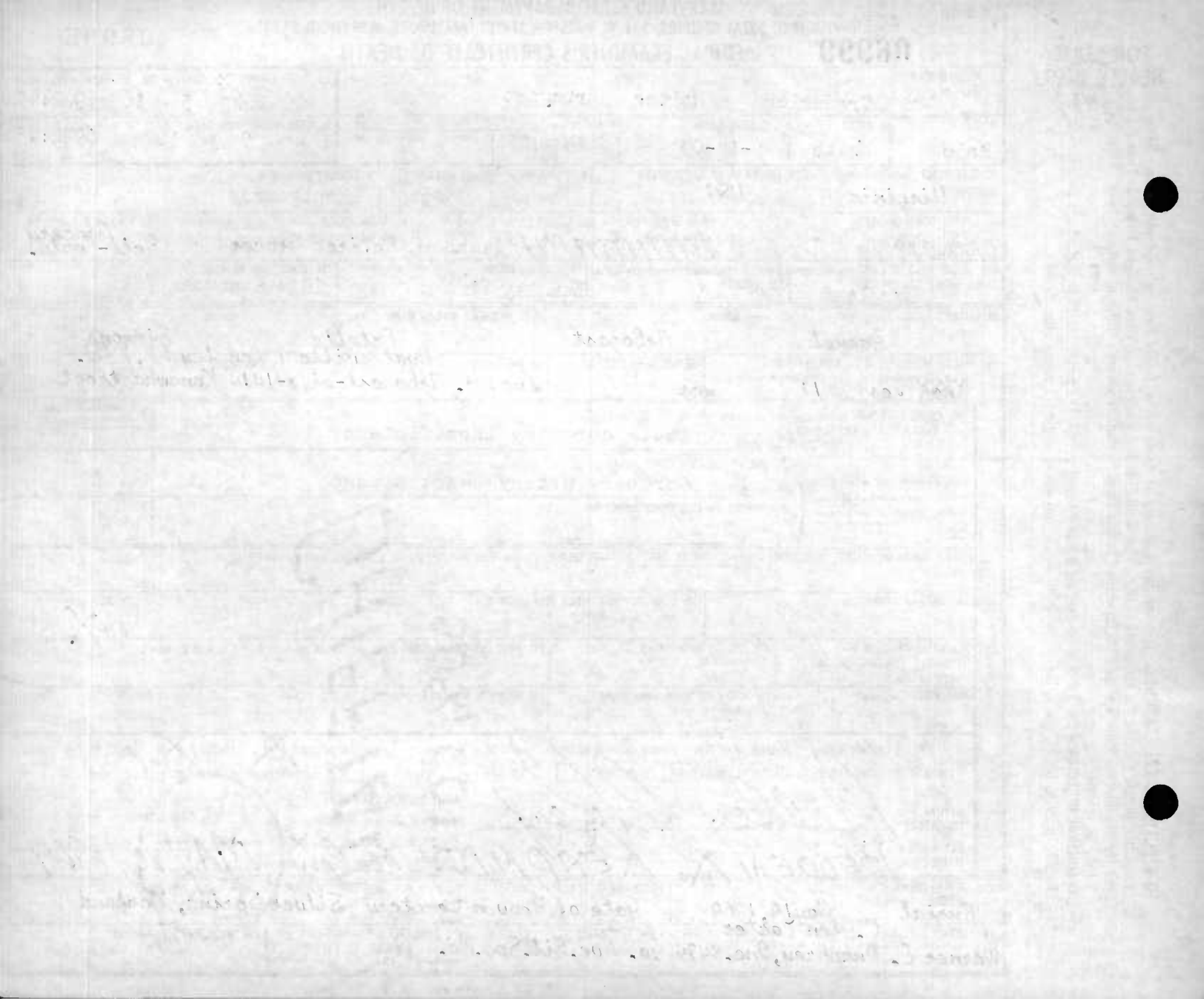
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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06995

1. DECEASED-NAME (Type or Print) <b>Frederick Walter Arbogast</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>5</b> Day <b>16</b> Year <b>1969</b>			2b. HOUR <b>2:45 AM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>7-14-04</b>	6. AGE (In years last birthday) <b>64</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>5</b> Day <b>16</b> Year <b>1969</b>	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hyattsville / Wash. D.C.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Grocer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self-Empld.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Langley Pk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>1414 Kanawaha / St</b>							
14. FATHER'S NAME First <b>Samuel</b> Middle <b>Arbogast</b> Last <b>Arbogast</b>			15. MOTHER'S MAIDEN NAME First <b>Estelle</b> Middle <b>Simmons</b> Last <b>Simmons</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>yes</b>		17. INFORMANT <b>Lucy H. Arbogast-wife-1414 Kanawaha Street</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary insufficiency</b> <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, Town, or county) <b>MAY 16, 1969</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 19, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc. 8434 Ga. Ave. Sil. Spg. Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 20 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





4469

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. John Bell notified & appeared

07000		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06996	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print) First Middle Lost <b>BESS FURMAN ARMSTRONG</b>			2a. DATE OF DEATH Month Day Year <b>MAY 12, 1969</b>			2b. HOUR <b>8 A M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>Dec. 2, 1894</b>		6. AGE (In years lost birthday) <b>74</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Nebraska</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Wood Acres</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>5904 Cobalt Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Writer-N.Y. Times</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Wood Acres</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>5904 Cobalt Road</b>		14. FATHER'S NAME First Middle Lost <b>Archie -- Furman</b>		15. MOTHER'S MAIDEN NAME First Middle Lost <b>Mattie -- Van Pelt</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-10-6549</b>		17. INFORMANT <b>Robert F. Armstrong, 6129-12th Rd. N., Arl., Va.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Metastasis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>October, 1967</b> , to <b>May 7, 1969</b> , that (I) (we) last saw the deceased alive on <b>May 7, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>George A. Boivis MD</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5-12-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>George A. Boivis</b>		22e. ADDRESS <b>5410 Connecticut Ave NW</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/15/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Sons, Washington, D.C.</b>		5130 Wisconsin Ave, NW		25a. REC'D BY REGISTRAR DATE <b>MAY 20 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1038

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

07001												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												06997											
1. DECEASED-NAME (Type or print) First Middle Last Betsey R. Arns												2a. DATE OF DEATH Month Day Year May 7 1969												2b. HOUR 7A.M.											
3. SEX Female				4. RACE Caucasian				5. DATE OF BIRTH July 21, 1885				6. AGE (In years last birthday) 83 1/4 YRS.				1E UNDER 1 YEAR MONTHS DAYS				1F UNDER 24 HRS HOURS MIN															
7a. BIRTHPLACE (State or foreign country) New York State				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md.																							
10. CITY OR TOWN OF DEATH Kensington				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Hall Sanitarium				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Investigator				12b. KIND OF BUSINESS OR INDUSTRY Met. Police																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Takoma Park				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 509 Philadelphia Ave.																			
14. FATHER'S NAME First Middle Last Edward A. Riddle				15. MOTHER'S MAIDEN NAME First Middle Last Jenny Abel				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No												16b. SOCIAL SECURITY NO. 577-01-6728A				17. INFORMANT Mrs. Dorothy Brown daughter 509 Philadelphia Ave. Takoma Park, D.C.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>central arterio-sclerosis</u> 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)								21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 68</u> , 19 <u>68</u> , to <u>May 7, 1969</u> , that (I) (we) lost the deceased on <u>May 7, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE <u>Lewis Phillip Deanes</u>												22c. DATE SIGNED <u>May 7, 1969</u>				22d. PHYSICIAN'S NAME (Type) <u>Lewis Phillip Deanes</u>								22e. ADDRESS <u>5916 Bullock Rd. S.S. Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE <u>May 8, 1969</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Grove Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Trumansburg, New York</u>				24. FUNERAL DIRECTOR <u>Paul J. Smith</u>				25a. REC'D BY REGISTRAR <u>May 12, 1969</u>				25b. REGISTRAR'S SIGNATURE <u>Charles C. ...</u>											

TO THE SECRETARY OF THE INTERIOR  
FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT  
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing land management activities, possibly related to a specific area or project. Key words that are faintly visible include "land", "survey", "report", and "recommendations".]

RECEIVED  
[Illegible text in the right margin, possibly a date or reference number]



# FOR STATE HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-155. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 412 MARYLAND STATE DEPARTMENT OF HEALTH  
5-22-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07002

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06998

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 5- 1 1969		2b. HOUR 6:05 A	
Joseph						Athey					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 5 1 Day Year 1969	
Male	Wh.	2-11-11		58 YRS						6:05 A	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Md.		US				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park		Washington San & Hosp.		carpenter		construction					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Pr. Geo		Laurel				Brooklyn Bridge Rd.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Benjamin F.		Athey						Mayr		Elizabeth M. Athey	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO				Mr. Roy J. Athey (brother)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>due to marked pulmonary emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED MAY 1, 1969	
EXAMINER'S NAME (Type)		Belden R. Reap M.D.		ADDRESS (Street, City, Town or County)							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		5-4-69		Union Cem.		Baltimore Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE					
Danaedran Funeral Home		Laurel Md.		MAY 6 1969		Charles Judge					

07002

FOR SALE  
FOR SALE



COAST GUARDIAN  
1000

174X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

07003

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06999

1. DECEASED-NAME (Type or print) <b>ELIZABETH LANDON BAMBER</b>			First Middle Lost			2a. DATE OF DEATH Month <b>05</b> Day <b>30</b> Year <b>69</b>			2b. HOUR <b>430P</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>8 August 1901</b>			6. AGE (In years lost birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>6015 Woodacres Dr.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6015 Woodacres Drive</b>		
14. FATHER'S NAME First Middle Lost <b>William Henry Landon</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth B. Finkler</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>579-58-3533</b>			17. INFORMANT Address <b>Millard B. KKK BAMBER above address</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>174X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of Breast</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>			
									<b>4 mos.</b>			
									<b>4 years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>5/27</b> , 19 <b>68</b> , to <b>5/30</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>5/27</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Frank Y. Jaggers Jr. M.D.</b>						22c. DATE SIGNED <b>5/30/69</b>						
22d. PHYSICIAN'S NAME (Type) <b>FRANK Y. JAGGERS JR.</b>						22e. ADDRESS <b>5707 WISCONSIN AVE Chevy Chase</b>						
23a. BURIAL, CREMATION, BURNING (Specify)			23b. DATE <b>6/2/69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Hampton, Virginia</b>			
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Bethesda, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>JUN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>				

07003

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# FOR STATE HEALTH DEPT.

07004

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07000

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
WILLIAM RUSSELL BARKER						Month Day Year			5 3 19 69 10:55		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	2/13/80	89s.					Month Day Year			19 69 10:55
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Virginia			Hanover County USA						Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hospital			paper hanger					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Mont.			SS			13e. STREET AND NUMBER		
									1107 Arcola Ave. Whet.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		
First Middle Last			First Middle Last			No			228-10-4793		
William N. Barker			Virginia H. Gibson								
17. INFORMANT			ADDRESS			17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			17b. SOCIAL SECURITY NO.		
niece June Bliss			1107 Arcola Ave. Whet.			No			228-10-4793		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Arteriosclerotic Heart Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M.			19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			MAY 3, 1969					
Belden R. Neap			ADDRESS (Street, City, Town, or county)								
Belden R. Neap M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			May 6, 1969			Hollywood Cemetery			Richmond, Virginia		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Paul Smith			MAY 7 1969			Charles Judge					
Warner E. Pumphrey, Inc., 8434 Georgia Avenue											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



07002

MEDICAL EXAMINING CERTIFICATE OF DEATH

3

x

STATE OF TEXAS

COUNTY OF DALLAS

CITY OF DALLAS

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

ADDRESS OF EXAMINER

SIGNATURE OF EXAMINER

NOTARY PUBLIC

COMMISSION EXPIRES

NOTARY PUBLIC

COMMISSION EXPIRES

NOTARY PUBLIC

COMMISSION EXPIRES

NOTARY PUBLIC

COMMISSION EXPIRES

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COMMISSION EXPIRES

NOTARY PUBLIC

COMMISSION EXPIRES

NOTARY PUBLIC

COMMISSION EXPIRES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

4109  
+ cleared 24th corner 2/16/69

07005

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07001

1. DECEASED-NAME (Type or print) <b>CHARLES M. BEALES</b>			2a. DATE OF DEATH Month <b>MAY</b> Day <b>26</b> Year <b>1969</b>			2b. HOUR <b>7:00 P.</b>	
3. SEX <b>Male</b>		4. RACE <b>Wh.</b>		5. DATE OF BIRTH <b>10/17/17</b>		6. AGE (In years last birthday) <b>51</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>T.V. Repair</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>T.V. Repair</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
13e. STREET AND NUMBER <b>5023- 59th Avenue</b>		14. FATHER'S NAME First <b>Charles</b> Middle <b>F.</b> Last <b>Beales</b>		15. MOTHER'S MAIDEN NAME First <b>Mamie</b> Middle <b>Duyer</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service) <b>WWII</b>		16b. SOCIAL SECURITY NO. <b>577-05-3478</b>		17. INFORMANT <b>Rosemary Beales - above address</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>5/26/69</b> , 19 <b>69</b> , to <b>5/26</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>5/26</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Harold W. Draper M.D.</b> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5/26/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>HAROLD W. DRAPER</b>				22e. ADDRESS <b>9801 GEORGIA AVE, Silver Spring, Md</b>			
23a. BURIAL, CREMATION, REMAINS (Specify) <b>Burial</b>		23b. DATE <b>5/29/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Wash., D.C.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>				ADDRESS <b>Mt. Rainier Maryland</b>		25a. REC'D BY REGISTRAR <b>2 1969</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

07005

DATE  
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000 3 110

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07006

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07002

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
MARY GENE Beckwith						MAY 26 1969			12:30 A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	White	July 17, 1927	47 YRS	MONTHS DAYS		HOURS MIN.		MAY 26 1969			12:30 A.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		Md.	
Pennsylvania		USA		WIDOWED		DIVORCED		Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		Suburban		Housewife		Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
VA			ALEXANDRIA		ALEXANDRIA		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		801 Summit Ave.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
PERNELL			WOLZ			CRESCENCE			HASKER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No						Roland A. Beckwith			Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: Massive intracerebral hemorrhage, spontaneous, left basal ganglia area										10 hours	
IMMEDIATE CAUSE (a) 4319 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF										years	
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		John G. Ball				M.D.		22b. DATE SIGNED		May 26, 1969	
EXAMINER'S NAME (Type)						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		5/30/69		West Hill Cemetery		Galeton		Potter		Pa.	
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons						Hyattsville, Maryland		JUN 2 1969		Francis Judge	

00050



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07007						07003					
1. DECEASED-NAME (Type or print) <b>MICHAEL A. BEDARD</b>						2a. DATE OF DEATH Month <b>MAY</b> Day <b>31</b> Year <b>1969</b>			2b. HOUR <b>12:10 P.M.</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>9/24/41</b>			6. AGE (In years last birthday) <b>27</b> YRS.		IF UNDER 1 YEAR MONTHS <b>27</b> DAYS <b>27</b> HOURS <b>27</b> MIN.		IF UNDER 24 HRS. HOURS <b>27</b> MIN.
7a. BIRTHPLACE (State or foreign country) <b>CANADA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>CANADA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUBURBAN</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>DRY WALL MAN</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>E.P. CONST. Co.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4602 BAYNE COURT</b>		
14. FATHER'S NAME First <b>Albert</b> Middle <b>Bedard</b> Last <b>Bedard</b>			15. MOTHER'S MAIDEN NAME First <b>Marie</b> Middle <b>Anne</b> Last <b>Lafond</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Louissette Bedard</b> Address <b>Same as item #13a</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovascular failure sec</b> <b>163.0</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>port of malignant mesothelioma (mesothelioma)</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>(pleural)</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>5-24</b> , 19 <b>69</b> , to <b>5-31</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>5-31</b> , 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>V. C. de Guzman</b>						22c. DATE SIGNED <b>1234 1989 NW Wash DC</b>		22d. PHYSICIAN'S NAME (Type) <b>V. C. de Guzman</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>6/1/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Villeroy Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Villeroy Quebec Canada</b>		23e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home Rockville, Md.</b>											

87007

87007

RECEIVED



UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.  
OFFICE OF THE SECRETARY  
RECEIVED

## CERTIFICATE OF DEATH

07004

1. DECEASED-NAME (Type or print) <b>Valerie Beeghly</b>			2a. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1969</u>			2b. HOUR <u>64</u> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <u>10/23/1882</u>		6. AGE (In years last birthday) <u>86</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wheaton Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Washington, DC</b>		13b. COUNTY <b>XXXXXXX</b>		13c. CITY OR TOWN <b>ZZZZ</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>JACOB</b> Middle <b>STUCKEY</b> Last <b>Emeline</b>		15. MOTHER'S MAIDEN NAME First <b>Emeline</b> Middle <b>Russell</b> Last <b>Russell</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) <b>NO</b> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO.		17. INFORMANT <b>John V. Bollock, Trust Officer</b> Address <b>Nat'l Bank of Washington, Washington, DC</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4109</b> IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF <b>CORONARY OCCLUSION.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF <b>15 YEARS</b> (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE, 1955</u> , to <u>MAY 14, 1969</u> , that (I) (we) last saw the deceased alive on <u>MAY 10, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Robert L. Krichmar</b>		DEGREE <b>ROBERT L. KRICHMAR</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>May 14 1969</u>	
22d. PHYSICIAN'S NAME (Type) <b>ROBERT L. KRICHMAR</b>		22e. ADDRESS <b>7733 ALASKA AVENUE NW WASHINGTON DC 20012</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>5/16/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bloomville, Ohio</b>	
24. FUNERAL DIRECTOR <b>The S.A. Harris Co.</b>		ADDRESS <b>2901 - 14th St. N.W. Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>4115 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Chapman</b>	

 4109  
 90  
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 1  
 MEDICAL EXAMINER.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07002

DEPARTMENT OF HEALTH

Division

State

Female

U. S. A.

Ohio

WEST VIRGINIA

Police

JOHN J. HOLLOMAN, M.D.

Info

Blountville

WEST VIRGINIA

10/10/09

10/10/09

4310

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07009

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07005

1. DECEASED-NAME (Type or print) <i>Lydia</i> First <i>J. Beehler</i> Middle <i>Lost</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>13</i> Year <i>1969</i>			2b. HOUR <i>3:30</i> P. M.					
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>9/14/97</i>		6. AGE (in years last birthday) <i>71</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maine</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Secretary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Govt.</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D. C.</i>		13b. COUNTY <i>—</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3201-11th St. N.W.</i>			
14. FATHER'S NAME <i>Thomas - Simpson</i> First <i>—</i> Middle <i>—</i> Last			15. MOTHER'S MAIDEN NAME <i>OLIVE</i> First <i>—</i> Middle <i>—</i> Last <i>THURSTON</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		(If yes give war or dates of service) <i>no</i>		16b. SOCIAL SECURITY NO. <i>578-24-1790</i>		17. INFORMANT <i>Vernon Beehler</i>		Address <i>State above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Hemorrhage</i> <i>431.0</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic Cerebral Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>21 hours</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Hypertension &amp; Diabetes Mellitus</i>											
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>—</i>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>—</i>		21f. LOCATION Street or R.F.D. No. City or Town County State <i>—</i>							
22a. I certify that (I) (this hospital) attended the deceased from <i>June 1965</i> to <i>May 13, 1969</i> , that (I) (we) saw the deceased alive on <i>May 13, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>P. P. Andrews M.D.</i>		DEGREE <i>—</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5-13-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>P. P. ANDREWS M.D.</i>		22e. ADDRESS <i>Washington D.C. 20016</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>5/16/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PARKLAWN CEMETERY</i>		23d. LOCATION (City or Town) (County) (State) <i>ROCKVILLE, MD.</i>					
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SONS</i>		ADDRESS <i>5130 WISCONSIN AVE. N.W.</i>		25a. REC'D BY REGISTRAR <i>—</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
		CITY <i>WASHINGTON, D.C.</i>		DATE <i>MAY 20 1969</i>							





2509

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07010										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07006				
1. DECEASED-NAME (Type or print) First Middle Last WARD C BELL										2a. DATE OF DEATH Month Day Year 5 21 69										2b. HOUR 7:20 P M				
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 7-27-80					6. AGE (in years lost birthday) 88 YRS.					IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) OHIO			7b. CITIZEN OF WHAT COUNTRY? U.S.A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH MONTGOMERY Md.													
10. CITY OR TOWN OF DEATH BETHESDA					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GROSSVENDOR LAKE N.C. CENTRE					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) M.D.					12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE Calif. Maryland					13b. CITY OR TOWN MONTGOMERY					13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 5326 N. Ingham									
14. FATHER'S NAME First Middle Last DAVID R BELL					15. MOTHER'S MAIDEN NAME First Middle Last ISABELLE CLUTTER					13d. STREET AND NUMBER 1500 BROADWAY														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. 278-32-9586 A					17. INFORMANT MRS ALISON CERRI					Address 4316 PINEY BRANCH Rd. SIL. SPG. MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis - 2509 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis (c) Diabetes Mellitus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate approx 40 yrs 50 yrs														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Chronic & Acute Cystitis - post op (many yrs) Carcinoma Penis -																								
19a. DATE OF OPERATION NOT Recently - 1964 Approx					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca penis					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 7, 1968, to 5/21, 1969, that (I) (we) lost saw the deceased alive on 5/19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE Israel Spector MD										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 5/21/69									
22d. PHYSICIAN'S NAME (Type) Israel Spector, MD										22e. ADDRESS 911 Silver Spring Ave., S.S. Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation					23b. DATE May 23, 1969					23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory					23d. LOCATION (City or Town) (County) (State) Bladensburg Rd. Md.									
24. FUNERAL DIRECTOR C. Glen Carter Warner C. Humphrey, Inc.										ADDRESS 8434 Ga., Ave., S.S.					25a. REC'D BY REGISTRAR MAY 26 1969					25b. REGISTRAR'S SIGNATURE Charles Judge				

01010

RECORD OF DEATH

1910-1911

1910-1911

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1910-1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07011		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07007	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
Phillip Bentley					Month 5	Day 1	Year 69 11:50 A
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS
Male	Cau.		Jan. 7, 1896		73 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
New York State	U.S.A.				Montgomery Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda, Md.		Grosvenor Lane Nursing Home		Government Emp.		Retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
D.C.		13b. COUNTY		Washington		13e. STREET AND NUMBER	
						1336 Missouri Ave., N.W.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		
Allen O. Bentley					Elizabeth Markham		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
Yes 1918-1919		579 60 2230		Freda S. Bentley - wife - same item # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 4109 congestive heart failure							2 hours
DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction							2 hours
DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis							chronic
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
cerebrovascular insufficiency							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		HOUR A.M. Month Day Year P.M. 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION			
				Street or R.F.D. No. City or Town County State			
				3/26 69 1 Way 69			
22a. I certify that (I) (this hospital) attended the deceased from April 20, 1969, to May 1, 1969, that (I) (we) last saw the deceased alive on April 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	
David Morowitz, M.D.		May 1, 1969		Dr. David Morowitz		9237 Three Oaks Drive, Silver Sprg. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		5/2/69		Cedar Hill Cemetery		Prince George Co. Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Tyson Wheeler Funeral Home		1331 Rock Pike Rockville, Maryland		MAY 3 1969		Charles Judge	

1950

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# FOR STATE HEALTH DEPT.

## 07012 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07008

1. DECEASED-NAME (Type or Print) <b>First Sarah Middle Rebecca Last Berg</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>May</b> Day <b>1</b> Year <b>1969</b>			2b. HOUR <b>5:45 AM</b>			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>July 30, 1880</b>	6. AGE (In years last birthday) <b>89 YRS.</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>May</b> Day <b>1</b> Year <b>1969</b>			
7a. BIRTHPLACE (State or foreign country) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>America</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington San. + Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Prince George's</b>			13b. CITY OR TOWN <b>Hyattsville</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER <b>8211 14th Street</b>			
14. FATHER'S NAME <b>UNKNOWN</b> First Middle Last			15. MOTHER'S MAIDEN NAME <b>Celia</b> First Middle Last <b>UNKNOWN</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>PT's Chart</b>			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4123 Acute Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <b>Belden R. Reap</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>May 1, 1969</b>			
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>5/2/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WASH. CENTRAL</b>		23d. LOCATION (City or Town) (County) (State) <b>HYATTSVILLE MD</b>			
24. FUNERAL DIRECTOR <b>Goodley Funeral Home 4217-9th Ave</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>MAY 5 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

2 No autopsy

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

21070



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (carap, papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07013		CERTIFICATE OF DEATH				07009			
1. DECEASED-NAME (Type or print) First Middle Last ALBERT J. BERLIN			2a. DATE OF DEATH Month Day Year 5 16 69			2b. HOUR M			
3. SEX M		4. RACE White		5. DATE OF BIRTH 9/16/1894		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethesda Silver Spring		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Merchant, Ret.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY MONT		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8505 Sp ingdale Rd.			
14. FATHER'S NAME First Middle Last Samuel Berlin			15. MOTHER'S MAIDEN NAME First Middle Last Anna Hamberger						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 159-03-7400		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4124 Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD (arteriosclerotic cardiovascular disease)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic lymphatic leukemia</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 1 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>17 Jan, 1966</u> , to <u>16 May, 1969</u> , that (I) (we) last saw the deceased alive on <u>15 May, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Horace Bernton</u> DEGREE				22c. DATE SIGNED		22e. ADDRESS 4743 Bradley Blvd., Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/18/69		23c. NAME OF CEMETERY OR CREMATORY Roosevelt Cemetery		23d. LOCATION (City or Town) (County) (State) Philadelphia, Pa.			
24. FUNERAL DIRECTOR Bernard Danzansky & Sons				ADDRESS 3501 14th St. S.E., Wash., D.C.		25. SIGNED BY REGISTRAR MAY 21 1969		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>	

07013

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07014

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07010

1. DECEASED-NAME (Type or Print) <b>EMILY A. BETTERIDGE</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>5</b> Day <b>12</b> Year <b>1969</b>			2b. HOUR <b>M</b>					
3. SEX <b>Fe</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH <b>3/17/1894</b>		6. AGE (In years) <b>75</b>		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>			
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b>		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>12336 Peach Orchard Rd.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>Washington DC</b>			13c. CITY OR TOWN <b>Washington DC</b>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
14. FATHER'S NAME First <b>Henry</b> Middle <b>Fermier</b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>Agnes</b> Middle <b>Schipe</b> Last <b></b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b></b>			16b. SOCIAL SECURITY NO. <b>577-03-8205</b>		
17. INFORMANT <b>Terrence Betteridge - same as above</b>			18. ADDRESS <b></b>			19. DATE OF OPERATION <b></b>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b></b>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b></b>			22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b></b>			21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>			22b. DATE SIGNED <b>MAY 12, 1969</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>			23b. DATE <b>5/14/69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>			23d. LOCATION (City or Town) (County) (State) <b>Montgomery County, Md.</b>		
24. FUNERAL DIRECTOR <b>The S. H. Hines Co.</b>			ADDRESS <b>Washington, D. C.</b>			25a. REC'D BY REGISTRAR <b>MAY 14 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

90/41/2

1. The following information was obtained from the records of the Federal Bureau of Investigation, Washington, D. C., on the subject of the above captioned case:

*M. L. White, D.O. covering for Raymond Bennett, D.O.*

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07015										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
07011										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR														
Edith					PEARL					Bielaski					Month Day Year					1P M									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
Female					Caucasian					12-1-79					89 YRS.														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
V.A.					UNITED STATES										Montgomery Md.														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Silver Spring					Holy Cross					AT HOME																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
Md.					Montgomery					Silver Spring					YES <input type="checkbox"/> NO <input type="checkbox"/>					2407 Glenallen Ave #3									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
James Hugh Harrington					Mary Ann Harrington					KERNEY																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT																			
NO					215-54-8345					JAMES BIELASKI, SON, 2801 NEW MEXICO AVE.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Renal Failure</u>																													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension</u>																													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>General arteriosclerosis</u>																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
<u>Cholelithiasis, Cholecystitis, Gallstones, Pancreatitis</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
					HOUR A.M. Month Day Year																								
					P.M. 19																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION					Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <u>13 May, 1969</u> , to <u>25 May, 1969</u> , that (I) (we) last saw the deceased alive on <u>24 May, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED									
Merton L. White MD																				25 May 69									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
Merton L. White										9911 Georgia Ave. N.W. Silver Spring, Maryland																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					5-28-1969					Mount Olivet Cemetery					Washington, D.C.														
24. FUNERAL DIRECTOR										ADDRESS					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
JOSEPH GAWLER'S SON, INC.										2130 WISC. AVE., N. W. WASH., D. C. 20016					MAY 28 1969					Charles Judge									



Charles H. Thompson  
 James H. Thompson  
 Mary Ann Thompson  
 James F. Thompson  
 Joseph H. Thompson  
 George H. Thompson  
 Charles H. Thompson

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07016		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07012	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last <b>JAMES BERNARD BLACKWOOD</b>			2a. DATE OF DEATH Month Day Year <b>MAY 17 1969</b>			2b. HOUR <b>8:55AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH <b>27 JUNE 1908</b>		6. AGE (In years last birthday) <b>60</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>NAVAL HOSP. BETHESDA, MD.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>USMC</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MONT</b>		13c. CITY OR TOWN <b>SILVER SPR.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>FRANKLIN J. BLACKWOOD</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MARGARET DEBOLT</b>		13e. STREET AND NUMBER <b>915 GABEL ST.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>234 44 2190</b>		17. INFORMANT Address <b>MRS. MARGARET BLACKWOOD, 915 GABEL ST. MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG WITH METASTASES</b> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 MONTHS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from <b>9 MAY</b> , 19 <b>69</b> , to <b>17 MAY</b> , 19 <b>69</b> , that (X) (we) last saw the deceased alive on <b>17 MAY</b> , 19 <b>69</b> , and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (XXXX) view the body after death.							
22b. SIGNATURE <b>James Trone</b>				22c. DATE SIGNED <b>17 May 1969</b>			
22d. PHYSICIAN'S NAME (Type) <b>CDR JAMES TRONE, MC, USN</b>				22e. ADDRESS <b>NAVAL HOSPITAL, BETHESDA, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>May 20, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON CEMETARY</b>		23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, ARLINGTON, VA.</b>	
24. FUNERAL DIRECTOR <b>COLLINS FUNERAL HOME 500 UNIVERSITY BLVD WEST</b>				25a. REC'D BY REGISTRAR <b>MAY 22 1969</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>	

01010

DATE: MAY 11 1968

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [REDACTED]

RE: [REDACTED]

REFERENCE: [REDACTED]

1. [REDACTED]

2. [REDACTED]

3. [REDACTED]

4. [REDACTED]

5. [REDACTED]

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07017		CERTIFICATE OF DEATH						07013	
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
HELEN JULIA BOYLE						MAY 10 1969			3:10 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
FEMALE		CAUCASIAN		AUGUST 8, 1919			49 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PA.		USA.				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA			US NAVAL HOSPITAL			HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
VA.			N.		ALEXANDRIA	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 511 E. LURAY AVE.			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
FRANK J. BREINER			MARY UNKNOWN REINBOLD						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO					LEO J. BOYLE, 511 E LURAY AVE., ALEX- ANDRIA, VA.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE BREAST WITH</u> <u>174X</u> DUE TO, OR AS A CONSEQUENCE OF <u>METASTASES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (H) (this hospital) attended the deceased from <u>28 APRIL</u> , 19 <u>69</u> , to <u>10 MAY</u> , 19 <u>69</u> , that (H) (we) last saw the deceased alive on <u>10 MAY</u> , 19 <u>69</u> , and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>H.E. Ashworth M.D.</u>					22c. DATE SIGNED <u>5-10-69</u>				
22d. PHYSICIAN'S NAME (Type) <u>H.E. ASHWORTH, MD.</u>					22e. ADDRESS <u>NAVAL HOSPITAL BETHESDA MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		5-14-69		Arlington National		Fort Myer, Virginia			
24. FUNERAL DIRECTOR <u>Alexandria, Va. Person</u>					25a. REC'D BY REGISTRAR DATE <u>MAY 15 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Richard S. Judge</u>		

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INDEX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07018

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07014

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First Verna	Middle H.	Last BOYLE	2a. DATE OF DEATH May 26 Month Day Year 69		2b. HOUR 4:30 PM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 30 January 1894		6. AGE (In years lost birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Minnesota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4400 East West Highway	
14. FATHER'S NAME First Julius		Middle Herman		15. MOTHER'S MAIDEN NAME First Unknown		Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service) ---		16b. SOCIAL SECURITY NO. 579-44-7602B		17. INFORMANT Bethesda, Md. Mr. John C. Boyle, 4400 East West Highway		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease, severe, associated 4123 DUE TO, OR AS A CONSEQUENCE OF with bronchial asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (he) this hospital) attended the deceased from May 23, 1969, to May 26, 1969, that (he) (we) lost saw the deceased alive on May 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE D. S. Horton, M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) D. S. HORTON, M.D.		22e. ADDRESS Naval Hospital, Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/28/69		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.			
24. FUNERAL DIRECTOR Jos. Gawler Sons				ADDRESS 15130 Wisconsin Ave., N.W. Washington, D.C.		25a. REC'D BY REGISTRAR DATE JUN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

07078

100

200-1-70-58

258/59

100-1-70-58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07019		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07015					
1. DECEASED-NAME (Type or print) <i>Agatha</i>		First <i>Agatha</i>		Middle <i>C.</i>	Last <i>Bradbury</i>		2a. DATE OF DEATH Month <i>5</i> Day <i>20</i> Year <i>69</i>		2b. HOUR <i>5:30</i> M		
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>10-30-88</i>		6. AGE (In years last birthday) <i>80</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Mass.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>				Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Chevy Chase</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4716 Bradley Blvd.</i>			
14. FATHER'S NAME First <i>John</i> Middle <i>Carney</i> Last <i>Katherine</i>		15. MOTHER'S MAIDEN NAME First <i>Katherine</i> Middle <i>Neighan</i> Last <i>Neighan</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>MRS. LONG D. CHAMBLISS, DAUGHTER, BETH, MD.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Failure, severe</i> <i>571.9</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cirrhosis of the Liver Severe</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>6 months</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR-A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>May 20, 1969</i> , to <i>May 20, 1969</i> , that (I) (we) last saw the deceased alive on <i>May 20, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Stewart Clapp M.D.</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5-20-1969</i>					
22d. PHYSICIAN'S NAME (Type) <i>Stewart Clapp M.D.</i>		22e. ADDRESS <i>5415 W. Cedar Lane Bethesda Md</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5-23-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>					
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SON, INC.</i>		ADDRESS <i>5130 WISC. AVE., N. W. WASH., D. C. 20018</i>		25a. REC'D BY REGISTRAR <i>MAY 23 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

01070

INSTITUTE OF SCIENCE

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BRISTOL

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Washington, D.C.

Rock Creek Cemetery

7-23-1909

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185X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07020		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07016	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
LLOYD F. BRAIN SR.					5 / 4 / 69		10:57A
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS
MALE	CAUCASIAN		9-18-97		71 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Iowa		U. S. A.				MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA, MD.		GROSVENOR LANE NURSING HOME		owner appliance store		Electric	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD.		P. G.		RIVERDALE		13e. STREET AND NUMBER	
						5406 KENILWORTH AVE.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		
JAMES HENRY BRAIN					MARY ELIZABETH SIMPSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
yes		578-20-02-73		MARGARET A BRAIN			
				Address			
				Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 185X Respiratory insufficiency							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF: (b) metastatic carcinoma of prostate							Hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
				574 69			
22a. I certify that (I) (this hospital) attended the deceased from Oct. 8, 1968, to May 4, 1969, that (I) (we) last saw the deceased alive on May 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22d. DATE SIGNED	
David Morowitz, MD		David Morowitz, MD		Bethesda, MD		5/14/69	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		5/7/69		Ft. Lincoln		Colmar Manor P. G. Md.	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR DATE	
Francis Gasch's Sons				Hyattsville, Md.		MAY 7 1969	
						25b. REGISTRAR'S SIGNATURE	
						K. J. J. J.	



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 413  
6-12-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07017

07021

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or Print) <b>JOHN</b>			First <b>JOHN</b>			Middle <b>NMN</b>			Last <b>BRANDON</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <b>5</b> Day <b>19</b> Year <b>1969</b>		2b. HOUR <b>3:20 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>6-17-39</b>		6. AGE (In years last birthday) <b>29</b> YRS.		IF UNDER 1 YEAR MONTHS <b>29</b>		IF UNDER 24 HRS DAYS <b>29</b>		2c. DATE PRONOUNCED DEAD Month <b>5</b> Day <b>19</b> Year <b>1969</b>		2d. HOUR <b>3:20 PM</b>	
7a. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>MONTGOMERY</b>			
10. CITY OR TOWN OF DEATH <b>OLNEY</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MONTGOMERY GENERAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>TRUCK DRIVER</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>SAND COMPANY</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>DISTRICT OF COLUMBIA</b>						13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>WASHINGTON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6100 14TH ST., N. W.</b>			
14. FATHER'S NAME First <b>JOHN</b> Middle <b>-</b> Last <b>BRANDON</b>						15. MOTHER'S MAIDEN NAME First <b>ELIZABETH</b> Middle <b>-</b> Last <b>-</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>577540937</b>				17. INFORMANT <b>MEDICAL RECORDS DEPT.</b>				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple internal injuries with</b> <b>816.0</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>exsanguination, incurred in truck accident.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>2:45 P.M. 5-19-69</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Deceased driving alone was thrown beneath truck when it struck tree and pole</b>									
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Street</b>				21f. LOCATION Street or R.F.D. No. <b>Rte 108 &amp; Little Patuxent</b>				City or Town <b>Howard</b>		County <b>Howard</b>		State <b>Md.</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>BELDEN R. BEAP</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>MAY 19, 1969</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. BEAP, M.D.</b>				ADDRESS <b>2100 N. W. 10th St.</b>				City or Town <b>Washington</b>				County <b>Washington</b>		State <b>D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>May 24/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>				23d. LOCATION (City or Town) (County) (State) <b>Landover R. Ges' Co. Md.</b>					
24. FUNERAL DIRECTOR <b>Martell Adams</b>				ADDRESS <b>Aguasco, Md.</b>				25a. REC'D BY REGISTRAR <b>JUN 2 1969</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			







TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07022

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Emma Evelyn Brierly</b>			2a. DATE OF DEATH <b>5</b> Month <b>9</b> Day <b>69</b>			2b. HOUR <b>10<sup>00</sup> P.M.</b>					
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>12/25/78</b>		6. AGE (In years last birthday) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Secretary</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>10610 Mantz Road</b>	
14. FATHER'S NAME First Middle Last <b>Thomas H. Brierly</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Fannie Mae Hughes</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>286-01-2324</b>			17. INFORMANT Address <b>Mrs. Gerald Ashour 10610 Mantz Road SS.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>039.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bacterial infection</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>67</b> , to <b>May 9</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>May 9</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Edward Richards M.D.</b> DEGREE 22d. PHYSICIAN'S NAME (Type)						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
23a. (BURIAL) CREMATION, REMOVAL (Specify)			23b. DATE <b>5/14/69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Kansas City Mo.</b>		
24. FUNERAL DIRECTOR <b>W. W. Chambers</b>			ADDRESS <b>1400 Chapin St.</b>			25a. REC'D BY REGISTRAR DATE <b>MAY 15 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

27022

Female  
Barn Swallow  
Montgomery  
Alabama  
June 10, 1902  
W. M. Anderson  
Montgomery, Ala.

485-X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07023

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07019  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Phillip Henry Bright			2a. DATE OF DEATH 5 17 69 Month Day Year			2b. HOUR 1:55AM					
3. SEX Male		4. RACE Colored		5. DATE OF BIRTH 8-2-94		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY retired		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Dayton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Green Bridge Rd.		
14. FATHER'S NAME First Middle Last Phillip Bright			15. MOTHER'S MAIDEN NAME First Middle Last Mary E. Giles								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 485X IMMEDIATE CAUSE (a) BRONCHITIS PNEUMONIA, BILAT. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) APLASTIC ANEMIA											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4/9, 1946, to 5/17, 1969, that (I) (we) lost saw the deceased alive on 5/16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles S. Whitaker, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/17/69			
22d. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D.						22e. ADDRESS CLARKSVILLE, M.D.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/20/69		23c. NAME OF CEMETERY OR CREMATORY Browns Chapel Cemetery			23d. LOCATION (City or Town) (County) (State) Dayton, Howard, Maryland			
24. FUNERAL DIRECTOR Robert L. Snowden						ADDRESS Rockville, Maryland		25a. REC'D BY REGISTRAR MAY 22 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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1929

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07024		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07020	
1. DECEASED-NAME (Type or print) <i>DOROTHY C. BROOKE</i>				2a. DATE OF DEATH Month <i>5</i> Day <i>28</i> Year <i>69</i>		2b. HOUR <i>1:30 A.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>Cac.</i>		5. DATE OF BIRTH <i>1-4-03</i>		6. AGE (In years last birthday) <i>66</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Home 1000 Daleview Dr.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>school clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>school Govt.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>		13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Mitchellville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>11401 Belvedere Rd.</i>		14. FATHER'S NAME First <i>Herbert</i> Middle <i>G.</i> Last <i>Hopkins</i>		15. MOTHER'S MAIDEN NAME First <i>Fannie</i> Middle <i>L.</i> Last <i>MOORE</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no or unknown) <input type="checkbox"/> (If yes give war or dates of service) <i>- - -</i>		16b. SOCIAL SECURITY NO. <i>578-62-5601</i>		17. INFORMANT Address <i>Lucia H. Starkey 11401 Belvedere Rd. Mitchellville</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Astrocytoma 2</i> <i>1929</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>March</i> , 196 <i>8</i> , to <i>May</i> , 196 <i>9</i> , that (I) (we) lost saw the deceased alive on <i>May 27</i> , 196 <i>9</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Peyton R. Evans Jr. MD</i>		22c. DATE SIGNED <i>May 28, 1969</i>		22d. PHYSICIAN'S NAME (Type) <i>Peyton R. Evans Jr.</i>			
22e. ADDRESS <i>4900 Mass. Ave. Wash DC 20006</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>June 2, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Paul Episcopal Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Alexandria, Virginia</i>	
24. FUNERAL DIRECTOR <i>Glen Carter</i>		24. ADDRESS <i>34 Georgia Avenue</i>		25a. REC'D BY REGISTRAR <i>JUN 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>	
26. FUNERAL HOME <i>Warner E. Pumphrey, Inc., Silver Spring, Md.</i>							

03081

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07025 8/15/69 13 Film 413 5/29/69 kk													DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													07021																																						
1. DECEASED NAME (Type or print) First Middle Last MOSES C. BROOKS													2a. DATE OF DEATH Month Day Year 5 - 18 - 69													2b. HOUR 11:30 AM																																						
3. SEX MALE													4. RACE NEGRO													5. DATE OF BIRTH 9 - 4 - 1894													6. AGE (In years last birthday) 68 YRS.													IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN												
7a. BIRTHPLACE (State or foreign country) Maryland													7b. CITIZEN OF WHAT COUNTRY? USA													8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>													9. COUNTY OF DEATH MONTGOMERY Md.																									
10. CITY OR TOWN OF DEATH BETHESDA													11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GROSVENOR LANE NURSING HOME													12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)													12b. KIND OF BUSINESS OR INDUSTRY																									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.													13b. COUNTY WASHINGTON													13c. CITY OR TOWN WASHINGTON													13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													13e. STREET AND NUMBER 36-S Street NW 2072 HMD/CLURE/ST												
14. FATHER'S NAME First Middle Last William H. Brooks													15. MOTHER'S MAIDEN NAME First Middle Last Annie R. Brooks																																																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown yes													16b. SOCIAL SECURITY NO. 511-09-0400													17. INFORMANT Address Rev. W. W. Gaines 3443 Holmead Pl. NW																																						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) chronic bronchitis and emphysema													APPROXIMATE INTERVAL BETWEEN ONSET AND OFATH acute chronic																																																			
19a. DATE OF OPERATION													19b. CONDITION FOR WHICH OPERATION WAS PERFORMED													20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>													20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)													21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969													21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>													21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)													21f. LOCATION Street or R.F.D. No. City or Town County State 21st 5118 69																																						
22a. I certify that (I) (the hospital) attended the deceased from saw the deceased alive on 5/15/69, and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													22b. SIGNATURE David Amowitz, MD, DEGREE													ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>													22c. DATE SIGNED 5/18/69																									
22d. PHYSICIAN'S NAME (Type)													22e. ADDRESS																																																			
23a. BURIAL, CREMATION, REMOVAL (Specify)													23b. DATE 5/22/69													23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial													23d. LOCATION (City or Town) (County) (State) Landover Md.																									
24. FUNERAL DIRECTOR R. N. Horton													ADDRESS 1324 You St NW													25a. REC'D BY REGISTRAR MAY 22 1969													25b. REGISTRAR'S SIGNATURE Charles Judge																									

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STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
ALBANY

IN SENATE  
JANUARY 10, 1900  
REPORT OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
JANUARY 10, 1899

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.  
1900

THE LAND OFFICE HAS THE HONOR TO ACKNOWLEDGE THE RECEIPT OF THE REPORT OF THE COMMISSIONERS OF THE LAND OFFICE IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE JANUARY 10, 1899.

ATTEST:  
JANUARY 10, 1900  
J. B. LIPPINCOTT & CO., PRINTERS.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

1. DECEASED-NAME (Type or print) <b>Edward Hutchins Brown</b>		2a. DATE OF DEATH <b>5</b> Month <b>10</b> Day <b>69</b> Year		2b. HOUR <b>8:50</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>6-9-84</b>	
6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>England</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Montgomery</b> Md.		10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban</b>	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Insurance-Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md.</b>		13b. COUNTY <b>mont.</b>		13c. CITY OR TOWN <b>Bethesda</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>10600 Kenilworth Ave.</b>			
14. FATHER'S NAME First Middle Last <b>John T. Brown</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>(Unknown)</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>505-16-7845</b>		17. INFORMANT <b>Son-in-law</b> <b>Donald F. Byers</b> Address <b>Same as Item 13.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>485X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Emphysema &amp; chronic bronchitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive heart failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4</b> Years <b>4</b> Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>occlusion left subclavian artery, nephrosclerosis, myocarditis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>5/10</b> , 19 <b>69</b> , to <b>5/10</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>5/10</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Allen J. O'Neill</b> M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>	
22c. DATE SIGNED <b>5/10/1969</b>		STAFF PHYS. <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) <b>Allen J. O'Neill</b>		22e. ADDRESS <b>Bethesda MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-14-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>	
23d. LOCATION (City or Town) <b>Merchantville, N. J.</b>		(County)		(State)	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>MAY 15 1969</b>	
25b. REGISTRAR'S SIGNATURE <b>William D. ...</b>					

01036

OFFICE OF DEATH

STATE OF NEW YORK

DEATH CERTIFICATE

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07027						CERTIFICATE OF DEATH			07023		
1. DECEASED-NAME (Type or print)		First JAMES		Middle ALGER		Last BROWN		2a. DATE OF DEATH 5 <sup>th</sup> Month 25 Year 69			2b. HOUR 1:15 PM
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7-11-17			6. AGE (In years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Locomotive Engineer			12b. KIND OF BUSINESS OR INDUSTRY B & O Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland			13b. CITY OR TOWN Germantown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 119				
14. FATHER'S NAME First Middle Last James Brown			15. MOTHER'S MAIDEN NAME First Middle Last Bertha Hall								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes			16b. SOCIAL SECURITY NO. 218-12-0450		17. INFORMANT Doris J. Brown (wife) Address Germantown, Md. Md. Admission Recd., Montgomery Gen. Hospital, Olney						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis &amp; Potts abscess</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mos.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 2, 1969</u> , to <u>May 25, 1969</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>May 24, 1969</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Frederick Moomau M.D.</u>		22c. DATE SIGNED 5-26-69									
22d. PHYSICIAN'S NAME (Type) Frederick Moomau, M.D.		22e. ADDRESS Medical Center, Sandy Springs, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 28, 1969		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery, Md.					
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		24a. ADDRESS 8434 Ga. Ave. Sil. Spg.		25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages (only) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07028

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07024

1. DECEASED-NAME (Type or print) <b>Rosie J. Brown</b>			2a. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1969</b>			2b. HOUR <b>4:30</b> MIN <b>A</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 31, 1899</b>		6. AGE (In years last birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Mt. Airy</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>RFD # 3</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Mt. Airy</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RFD # 3</b>	
14. FATHER'S NAME First Middle Last <b>Chaplin Beall</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Priscilla J. Beall</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mr. R. Dewey Brown, Mt. Airy, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the colon with generalized metastases</b> <b>1538</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/16</b> , 19 <b>47</b> , to <b>5/16</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>5/16</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James P. Kerr</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>May 16, 1969</b>			
22d. PHYSICIAN'S NAME (Type) <b>James P. Kerr, M.D.</b>				22e. ADDRESS <b>Damascus, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 18, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Montgomery Meth.</b>		23d. LOCATION (City or Town) (County) (State) <b>Clagettville, Md.</b>			
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 20 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

03083

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C. 20250

May 11, 1960

Dear Sir:

I am pleased to inform you that your application for a

license to practice as a professional engineer has been

approved by the Board of Professional Engineers.

You are hereby notified that you are now a member of the

Professional Engineers of the State of California.

Very truly yours,

Secretary of the State

Enclosed for you are two copies of the certificate of

registration and a copy of the rules and regulations of the

Board of Professional Engineers.

I am sure that you will find this information of interest.

Sincerely,

Secretary of the State

Enclosed for you are two copies of the certificate of

registration and a copy of the rules and regulations of the

0389

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07029					07025						
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Danielle			MMN		BRYAN	May 28 1969			2:00 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR			
Female		Cauc		17 May 1969		YRS.		MONTHS	DAYS		
								HOURS			
								MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			Naval Hospital, Beth Md			None					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Virginia			Fairfax		Falls Church		YES <input type="checkbox"/> NO <input type="checkbox"/>		2202 Iroquois Lane		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Herbert			Francis	Bryan		Susan				Bowry	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			NONE			Herbert F. Bryan			2202 Iroquois Lane Falls Church, Va		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Neonatal Sepsis											
038.9 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (1) (this hospital) attended the deceased from 23 May, 1969, to 28 May, 1969, that (X) (we) last saw the deceased alive on 28 May, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Franklin X. Loeb						22c. DATE SIGNED 28 May 1969		22d. PHYSICIAN'S NAME (Type)			
Franklin X. Loeb						22e. ADDRESS		Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial			6-2-1969		Arlington Hall Cem		77 Myers		Va.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W.W. Chambers Funeral Home, 3072-17 St Md						JUN 2 1969		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Baby Girl Bryant						Month 5 Day 25 Year 69		11:30 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		white		5/24/69		YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Montgomery Co.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban Hosp							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Montgomery		Kensington		YES		4006 Decatur Ave	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
			Rachel V. Bryant							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
					Chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>										
7762 DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Pneumonia + Sepsis</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>5/24</u> , 19 <u>69</u> , to <u>5/25</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/24</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.										
22b. SIGNATURE					22c. DATE SIGNED					
<u>Arthur B. Krenker M.D.</u> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		5/25/69			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
23a. BURIAL (CREMATION, REMOVAL) (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
		5/26/69		Suburban Hospital		Bethesda - Montgomery - Md				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Mrs. Amelia C. Carter, Administrator					MAY 29 1969					

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2nd Edition

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1. *Staphylococcus aureus*

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Figure 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Della			W. Burdette			5 1 69			5:40 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		6-30-84			84 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring			Holy Cross			Operated Funeral Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Montgomery		Damascus			26401 Ridge Rd.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William T. Lewis			Laura Williams						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			579-64-7782		Austin L. Beall		813 Miss. Ave N.E. Wash. D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Renal Insufficiency, Diabetes Mellitus, Urinary Tract Infection									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1962, to 5/1, 1969, that (I) (we) last saw the deceased alive on 5/1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Norman H. Rubenstein M.D.					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/1/69		
22d. PHYSICIAN'S NAME (Type) Norman H. Rubenstein, M.D.					22e. ADDRESS 11161 N.H. Ave Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 3, 1969		Damascus Meth.		Damascus, Md.			
24. FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md.					25a. REC'D BY REGISTRAR DATE RAV 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

16082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14 07032

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07028

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR		
SARAH			Frances	BURRIS		5-11-69			2:20 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS.	
F		W		3-11-88		81 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
TAKOMA PARK		WASH SAN HOSP		RETIRED		Housekeeper					
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MD		PG		HYATTSVILLE				7918 14TH AVE, #101			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
David			-	KNIGHT		unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT					
No			214-36-2869			Herman D. Burriss (Son) Mt. Rainier, Md. 3103 Queens Chapel Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) acute pulmonary insufficiency										3 d	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic granulomatous lung disease with Cavitation CM ROXIC											
DUE TO, OR AS A CONSEQUENCE OF (c) undetermined (? Tbc)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
acute pneumoniae both lower lobes											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 5/13, 1969, to 5/17, 1969, that (I) (we) last saw the deceased alive on 5/10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)						
Henry W. Stout MD		5/12/69			HENRY W. STOUT MD						
22e. ADDRESS		10011 GEORGIA AVE SILVER SPRING MD									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		May 15, 1969		Burtonsville Union Cem.		Burtonsville		Maryland			
23e. FUNERAL DIRECTOR		23f. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
C. Glen Carter		Silver Spring, Maryland		MAY 14 1969		Warner E. Pumphrey, Inc., 8434 Georgia Avenue Charles Judge					

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STATE OF NEW YORK



1915-16-17

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07033

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07029

1. DECEASED-NAME (Type or Print)			First Glenn	Middle William	Last Cade	111	2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5-24-69	Month 5	Day 24	Year 19 69	2b. HOUR 1:43
3. SEX Male	4. RACE White	5. DATE OF BIRTH 1-27-63	6. AGE (In years last birthday) 6 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 5	Day 24	Year 19 69	2d. HOUR 1:43		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Prince George		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1911 Red Oak Dr.		
14. FATHER'S NAME First Glenn William			Middle Cade 11			15. MOTHER'S MAIDEN NAME First Christine			Middle Powers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT House Chart			ADDRESS Ross		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Due to gunshot wound of head.</u> (b) <u>Due to gunshot wound of head.</u> (c) <u>of head.</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 7:00 A.M. 5-21-69				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 18 or Part 21b) Deceased, while playing with pistol shot self in left eye			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No. (City or town) County State 1911 Red Oak Dr. Adelphi R. George Md			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED MAY 24, 1969			
EXAMINER'S NAME (Type) BELDEN R. REAP MD.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (City, town, or county) Adelphi, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/26/69		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln cemetery				23d. LOCATION (City or town) (County) (State) Bladensburg Md.			
24. FUNERAL DIRECTOR Paul J. Smith Varner E. Pumphrey, inc. 8434 Ga. ave Sil. Spr.						25a. REC'D BY REGISTRAR DATE MAY 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

03030

FOR STATE  
OF KANSAS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

X

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13

Name of deceased		Date of death	
Place of death		Time of death	
Cause of death		Manner of death	
Disease or condition		Injury or violence	
Signature of medical examiner		Signature of physician	
Date of examination		Date of death	

X

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07034

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

07030

1. DECEASED-NAME (Type or print) First Middle Last <b>Frank (Francis) P. Cahill</b>			2a. DATE OF DEATH Month <b>5</b> Day <b>18</b> Year <b>69</b>		2b. HOUR <b>1 A</b> M
3. SEX <b>m</b>	4. RACE <b>Can</b>		5. DATE OF BIRTH <b>2-20-1892</b>		6. AGE (In years lost birthday) <b>77</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>montgomery</b> Md.
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cherry Chase Conv. Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>usn Engineer</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md</b>		13b. COUNTY <b>montgomery</b>	13c. CITY OR TOWN <b>Silver Spr.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>8361 16th St.</b>
14. FATHER'S NAME First Middle Last <b>michael</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>margaret Morrison</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>yes</b>		16b. SOCIAL SECURITY NO. <b>215-44-5575A</b>		17. INFORMANT Address <b>m. jansen RN Cherry Chase Conv. Center</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac &amp; Cerebral Ischemia</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10-12 days</b> <b>3-5 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>June 3, 1959</b> , to <b>May 18, 1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>May 18, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>W.B. Wardrop MD</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>W.B. WARDROP MD</b>		22e. ADDRESS <b>808 PERSHING DRIVE SILVER SPRING MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 21, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	
23d. LOCATION (City or Town) (County) (State) <b>Silver Spring Mont. Md.</b>					
24. FUNERAL DIRECTOR <b>James J. Collins</b>		25a. REC'D BY REGISTRAR <b>MAY 22 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

07035

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07031

1. DECEASED-NAME (Type or print) First Middle Last <b>LUCY MAY CALLAHAN</b>			2a. DATE OF DEATH Month 8 Day 1969 Year 15:4 M		2b. HOUR
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>May 7, 1882</b>		6. AGE (In years lost birthday) <b>87</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Montgomery</b>		Md.			
10. CITY OR TOWN OF DEATH <b>Kensington, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Kensington Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>OWINGS MILLS</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>114 Pleasant Hill Rd.</b>			
14. FATHER'S NAME First Middle Last <b>CHARLES KOHL</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>KATHERINE KANSHER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>Stone</b>			16b. SOCIAL SECURITY NO. <b>unknown</b>		
17. INFORMANT <b>MRS FRANCES W. SATTERFIELD</b>			<b>131 DODGEN PALM BEACH, FLA.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4309</b> IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>trauma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Semility</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1, 1966</b> , to <b>May 8, 1969</b> , that (I) (we) last saw the deceased alive on <b>6 May 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Joacel Bern</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>Joacel Bern</b>				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>May 10, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Ridge</b>	
23d. LOCATION (City or Town) (County) (State) <b>Pikesville, Md.</b>					
24. FUNERAL DIRECTOR <b>Frank H. Newell</b>		25. RECEIVED BY REGISTRAR <b>Pikesville, Md.</b>		26. REGISTRAR'S SIGNATURE <b>James Judge</b>	
27. DATE <b>MAY 12 1969</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07036					07032				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last W. KENNETH CARLIN					2a. DATE OF DEATH Month Day Year MAY 28 1969			2b. HOUR 1:30 P. M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan 9 - 1887		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bonds - Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farm owner		12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Montg.		13c. CITY OR TOWN Bonds		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last John Thomas Carlin					15. MOTHER'S MAIDEN NAME First Middle Last Frances Bernadette Himmel				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 219-36-4789		17. INFORMANT Address Miss Frances Carlin 1900 S. Eads St. Arlington Va			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 10 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH instantaneous									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Gouty arthritis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 1948, to May 28, 1969, that (I) (we) last saw the deceased alive on May 9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John Fawcett					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/28/69		
22d. PHYSICIAN'S NAME (Type) JOHN Fawcett					22e. ADDRESS P.O. Bonds, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/31/69		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cath.		23d. LOCATION (City or Town) (County) (State) Barnesville Montg. Md			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

07030

RECEIVED OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

<div>07037</div> <div>Item 13 Film 413 6/9/69 kk</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>07033</div>											
1. DECEASED-NAME (Type or print)					First Middle Last		2a. DATE OF DEATH Month Day Year		2b. HOUR P 4:20 M		
CLARA BELLE CASHELL							5 24 69				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 11/7/74		6. AGE (In years lost birthday) 94 94		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GEN. HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. CITY OR TOWN OLNEY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 1301 Mass. Ave. NW		SHARON NURSING HOME			
14. FATHER'S NAME First Middle Last Fletcher ERVIN					15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth ANN HOWES						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 21854-6150		17. INFORMANT MEDICAL RECORDS		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Asystole</u> 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.H.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Fractured R Hip</u>											
19a. DATE OF OPERATION May 21/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fx of R Hip		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. May 18 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell from chair May 18/69 Sharon Nursing Home							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Nursing Home		21f. LOCATION Street or R.F.D. No. City or Town County State Ashton Mont. MD							
22a. I certify that (I) (this physician) attended the deceased from May 22, 1969, to May 25, 1969, that (I) (we) last saw the deceased alive on May 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Dr. Lorenzo Marcolin				BAND DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-26-69			
22d. PHYSICIAN'S NAME (Type) Dr. Lorenzo Marcolin				22e. ADDRESS Rockville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/27/6		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		23d. LOCATION (City or Town) (County) (State) Sunshine Mont. Md.					
24. FUNERAL DIRECTOR Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE MAY 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

07037

OFFICE OF STATE

STATE OF NEW YORK

IN SENATE

January 1, 1903

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REPORT OF THE

STATE

1902

1902

STATE OF NEW YORK

1902

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ROCKVILLE, Md.

Dr. Lorenzo Mercutio

Mr. General

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Rockville, Md.

Francis H. Barber

MAY 1 1903

Rockville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Elizabeth Virginia Cator						May 4 1969			4:20 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
Female		White		January 19, 1911		58 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington D.C.		U.S.A. America				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park			Washington Sanitarium			Saleslady			Bakery
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Prince George Hyattsville				3212 76th Avenue		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Lawrence Payne			Virginia Harrison						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			579 12 8925		Patient's chart				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus, Bronchial Pneumonia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>68</u> , to <u>5-4</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-2</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Stuart L. Nelson</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5-4-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/6/69		Ft. Lincoln		Colmar Manor P.G. Md.			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR MAY 7 1969 DATE		
Francis Gasch's Sons					Hyattsville. Md.		25b. REGISTRAR'S SIGNATURE <u>Alvin Judge</u>		

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> <span>07039</span> <span>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</span> <span>07035</span> </div>									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
William R Caulfield						Month Day Year			13 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male	White	10/31/1898	70 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year	2d. HOUR
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
Maryland		USA				Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			Suburban						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
Md			Mont			Guthrie			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13a. STREET AND NUMBER			
First Middle Last			First Middle Last			11520 Jane Plummer Rd			
William R Caulfield			Elizabeth Hilton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS
No			717-86-5038			Shirley May Bynum			Same as above
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia Acute.</u>									3 days.
4124 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular Disease.</u>									Years.
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				HOUR A.M. P.M.		19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			22b. DATE SIGNED			
John S. Ball						May 28, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			5-31-69		St Rose Cemetery		Guthrie, Md		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ernest O. Gartner			Guthrie, Md			JUN 2 1969		John S. Ball	

07032

UNITED STATES DEPARTMENT OF AGRICULTURE

7-2034

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07040

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

07036

1. DECEASED-NAME (Type or print) <b>NICOLA</b>		First		Middle		Last		2a. DATE OF DEATH Month Day Year <b>MAY 11 1969</b>			2b. HOUR <b>12:45</b> M		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>3/27/06</b>			6. AGE (In years last birthday) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b>			Md.				
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUBURBAN</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>TILE SETTER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4601 CASHWAY DRIVE</b>					
14. FATHER'S NAME <b>GENNARO CELENZA</b>		First		Middle		Last		15. MOTHER'S MAIDEN NAME <b>—</b>		First		Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>577-05-3890</b>		17. INFORMANT <b>(Wife) MARY S. CELENZA</b>			Address <b>Rockville, Md. 4601 CASHWAY DR.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL METASTASES</b> <b>1890</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF KIDNEY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>1 YEAR</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>AORTIC VALVULAR INSUFFICIENCY; UREMIA; PULMONARY METASTASES</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1967</b> , to <b>MAY 10, 1969</b> , that (I) (we) last saw the deceased alive on <b>MAY 4, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Joseph D. Connor M.D.</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>MAY 10, 1969</b>			
22d. PHYSICIAN'S NAME (Type) <b>Joseph D. Connor</b>		22e. ADDRESS <b>9420 Old Georgetown Rd., Bethesda, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 13, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Montgomery, Md.</b>							
23e. FUNERAL HOME OR ADDRESS <b>Warner E. Pumphrey, Inc., 8434 Georgia Avenue</b>		23f. ADDRESS <b>Silver Spring, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

62052

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form 1-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Medical examiner notified J.R.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
JOHN				HOWARD Chadwick,	MAY 7 1969		5	7	69	6:45 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male	White	3/17/25		44 YRS.	MONTHS DAYS		HOURS MIN		Month Day Year	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		2d. HOUR
New Jersey		USA		WIDOWED		DIVORCED		Montgomery		6:45 PM
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring, Md.		Holy Cross Hospital		Sales Executive						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.		Howard		Laurel		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11225 Martalini Dr.		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
John Howard Chadwick		Killian F. Basson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
Yes		1943-1946		Mrs. Betty Chadwick		2512 11225 Martalini Dr.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a)										
4123 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Arteriosclerotic heart disease										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		22b. DATE SIGNED				
EXAMINER'S NAME (Type)		BELOEN R. REAP		DEPUTY MEDICAL EXAMINER		May 7, 1969				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		5/10/69		Emmanuel Cemetery		Seagoville Md				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Danaedson Funeral Home		Laurel Md		MAY 19 1969		Charles Judge				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07042		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07038			
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Lucille		Stella	CHRISTENSEN		May	Month 21	Day 69	Year	615PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		Caucasian		Nov. 3, 1904		64		6 18	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Illinois		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Naval Hospital		Housewife		N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Montgomery		Bethesda		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10509 Montrose Ave.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Henry			Siegenthaler		Hedwick			von Griebaun	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No				219 48 5262		46 Horseshoe Rd.		Gullford, Conn	
						Mrs. Barbara O'Donnell,		46 Horseshoe Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra cerebral hemorrhage									
4319 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (this hospital) attended the deceased from May 19, 1969, to May 21, 1969, that (x) (we) lost saw the deceased alive on May 21, 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED			22d. ADDRESS				
Evans Diamond, M. D.		May 23, 1969			Naval Hospital, Bethesda, Md.				
22e. ADDRESS		22f. ADDRESS			22g. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5-26-69		Arlington National		Arlington Arlington Va.			
24. FUNERAL DIRECTOR		24a. RECD BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Robert A. Pumphrey Funeral Home		JUN 2 1969		Richard A. Judge					
7557 Wisconsin Ave., Bethesda, Md.									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07043

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07039

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Henri deBalathier CLAIBORNE					May 5 1969		11:07 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost by day)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		Caucasian		Aug. 11, 1903		65 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Louisiana		USA				Montgomery		Officer	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					
Bethesda		Naval Hospital		U. S. Navy					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Virginia		Essex		Center Cross		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		****	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Fernand Claiborne		Louise Villere							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes 1926 - 1947		224-62-2768		Wife		Mrs. Harriot Claiborne, Center Cross, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Esophagus</u> <u>150 X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <u>X</u> (this hospital) attended the deceased from <u>April 27</u> , 19 <u>69</u> , to <u>May 5</u> , 19 <u>69</u> , that <u>X</u> (we) last saw the deceased alive on <u>May 5</u> , 19 <u>69</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>X</u> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Mitchell Mills</u>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>6 May 1969</u>			
22d. PHYSICIAN'S NAME (Type) <u>MITCHELL MILLS, CDR MC USN</u>		22e. ADDRESS <u>Naval Hospital, Bethesda, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5-8-69		Arlington National Cem.		Arlington, Virginia			
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Funeral Home</u>		25a. REC'D BY REGISTRAR <u>May 12 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Soder</u>			
7557 Wisconsin Ave., Bethesda, Maryland									

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last DAVID — CLUCK						2a. DATE OF DEATH Month Day Year 5 29 69			2b. HOUR 1:45 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 10-3-89		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) N.Y. CROSS			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MERCHANT			12b. KIND OF BUSINESS OR INDUSTRY JEWELER		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MASS.			13b. COUNTY FALL RIVER, MASS			13c. CITY OR TOWN FALL RIVER, MASS		13d. INTER-CITY TRAVEL YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 638 WEETAMOE ST.	
14. FATHER'S NAME First Middle Last LAZAR CLUCK				15. MOTHER'S MAIDEN NAME First Middle Last BLUMA HARRIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown YES				16b. SOCIAL SECURITY NO. 0001		17. INFORMANT 638 WEETAMOE ST FALL RIVER, MASS.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 Carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from April, 1969, to May, 1969, that (I) (we) last saw the deceased alive on May 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Blaine H. Eig				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/29/1969	
22d. PHYSICIAN'S NAME (Type) BLAINE H. EIG				22e. ADDRESS 9401 Deerpark Lane Silver Spring, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6-1-69		23c. NAME OF CEMETERY OR CREMATORY NAT'L MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FALLS CHURCH VA.					
24. FUNERAL DIRECTOR GONDBERG FUNERAL HOME 4217 42nd St. N.W.				ADDRESS		25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE William J. Judge			

03042

RECEIVED FROM THE DIRECTOR, BUREAU OF LAND MANAGEMENT  
U.S. DEPARTMENT OF THE INTERIOR

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
DATE: [illegible]  
[illegible text follows in several paragraphs, mostly illegible due to fading and bleed-through]

4329  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07045

CERTIFICATE OF DEATH

07041

1. DECEASED-NAME (Type or print) <i>Hennetta</i> First Middle Last <i>Cole</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>29</i> Year <i>1969</i>			2b. HOUR <i>2:05</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>10/11/81</i>		6. AGE (In years last birthday) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>MICHIGAN</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>101 Lucerne Lane</i>	
14. FATHER'S NAME First <i>ADELBERT</i> Middle <i>E.</i> Last <i>CHASE</i>			15. MOTHER'S MAIDEN NAME First <i>FLORENCE</i> Middle <i>-</i> Last <i>Wilbur</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>220-44-4251</i>		17. INFORMANT Address <i>MRS. LEWIS DIESCHLER - SAME AS #13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolus</i> <i>4329</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Thrombophlebitis, femoral</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Paraplegia due to spinal artery thrombosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 minute</i> <i>3 days</i> <i>10 days</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Papillary ulcer</i> <i>Interventricular heart disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 19 <i>56</i> , to <i>5-29</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5-28</i> , 19 <i>69</i> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Seruch T. Kimble M.D.</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5-29-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Seruch T. Kimble, M.D.</i>				22e. ADDRESS <i>9801 Georgia Ave, Silver Spring, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>6/2/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>			
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, 5130 Wis. Ave, Wash., D.C.</i>				ADDRESS		25a. REC'D BY REGISTRAR DATE <i>JUN 5 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

07063

RECEIVED AT NEW YORK

RECEIVED AT NEW YORK

WILLIAM

Bernard T. Kimple, N.Y.

William, Maryland

Edward Hill Laboratory

02/2/69

Operation

London Jeweler's Store, 2100 Ave. Wash., D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07046

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07042

1. DECEASED-NAME (Type or print) <b>EDITH W. COSGROVE</b>			2a. DATE OF DEATH Month <b>5</b> Day <b>8</b> Year <b>69</b>			2b. HOUR <b>3:30 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>7-18-88</b>		6. AGE (In years lost birthday) <b>87</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.	
10. CITY OR TOWN OF DEATH <b>KENSINGTON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>KEN. GAR. SAN.</b>		12a. USUAL OCCUPATION (Kind of work done during most of waking life, even if retired.) <b>SALES LADY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SALES</b>	
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>CONCHEASQUE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <b>ALFRED</b> Middle <b>WAGNER</b> Last <b>WAGNER</b>		15. MOTHER'S MAIDEN NAME First <b>Laura</b> Middle <b>C.</b> Last <b>WARNER</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <b>214-34-7615</b>		17. INFORMANT <b>SON</b>		Address <b>49 E FRANKLIN HAGERSTOWN MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic cerebral vascular dis.</b> <b>4379</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>lost.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>20 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/26</b> , 19 <b>68</b> , to <b>8/8</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>8/8</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8/8/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>D F Kreuzburg</b>		22e. ADDRESS <b>2152 16th St NW Wash DC</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		23b. DATE <b>5/11/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem Greenbelt Md</b>		23d. LOCATION (City or Town) (County) (State) <b>Greenbelt Md</b>	
24. FUNERAL DIRECTOR <b>R.E. Minnich</b>		ADDRESS <b>Greencastle Pa</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 12 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

03080

DEPARTMENT OF HEALTH

1918-1919  
Smallpox  
No. 1000  
Name  
Address  
City  
State  
County  
Occupation  
Date of birth  
Date of death  
Cause of death  
Place of death  
Place of burial  
Remarks

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
LeRoy			(None) Covert			May 25 1969			12 A M
3. SEX		4. RACE		5. DATE OF BIRTH		8. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		2 - 24 - 88		61 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York		U.S.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park			Washington San. & Hosp			Retired - Gov't			U.S. Gov't.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Maryland			Montgomery			Silver Spring			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
First Middle Last			First Middle Last			8803 Eastern Avenue.			
Anthony			Covert			Catherine Townsend Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
Yes			U.W.I.			Myrtle R. Covert-8003 Eastern Ave., Takoma Pk.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Pulmonary Embolism									sudden
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left Spleen Thrombosis									9 days
DUE TO, OR AS A CONSEQUENCE OF (c) Chr. Hg. Myocarditis occ. 12 camp -									9 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
Marked Emphysema									3 1/2 yrs
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
				4118 / 1969 5/25/69					
22a. I certify that (I) (this hospital) attended the deceased from 4/18/69, to 5/25/69, that (I) (we) last saw the deceased alive on 5/24/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
Howard T. Morse						<input checked="" type="checkbox"/>		22c. DATE SIGNED 5/25/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Howard T. Morse				7030 Carroll Ave Takoma Park Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 28 1969		Fort Lincoln Cemetery		Bladensburg, Maryland			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
C. Glen Carter				8434 Georgia Avenue		MAY 28 1969		Charles Judge	
Warner E. Pumphrey, Inc., Silver Spring, Md.									

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07044

1. DECEASED-NAME (Type or Print) <i>William</i> First <i>Murphy</i> Middle <i>Cravens</i> Last <i>III</i>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <i>May</i> Day <i>11</i> Year <i>1969</i>		2b. HOUR <i>10 P</i>
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>8/4/1932</i>	6. AGE (in years) <i>36</i> YRS	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	IF UNDER 24 HRS. HOURS <i></i> MIN <i></i>
7a. BIRTHPLACE (State or foreign country) <i>Delaware</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>
10. CITY OR TOWN OF DEATH <i>Montgomery</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>		13b. COUNTY <i>Mont</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>Richards Apts 10690 Weymouth Ave</i>
14. FATHER'S NAME First <i>Wilson M</i> Middle <i></i> Last <i>Cravens III</i>		15. MOTHER'S MAIDEN NAME First <i>Alice</i> Middle <i></i> Last <i>Thayer</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes give war or dates of service) <i>Air Force</i>	
16b. SOCIAL SECURITY NO. <i>528-34-6033</i>		17. INFORMANT <i>Mrs. Alison Cravens</i>		ADDRESS <i>Alex., Va.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Barbiturate poisoning</i> <i>9500</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Overdose of barbiturates</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>10:00 P.M. May 11, 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Took overdose of barbiturates</i>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Apartment</i>		21f. LOCATION Street or R.F.D. No. City or Town County State <i>10690 Weymouth Ave. Bethesda Montg. Md.</i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John S. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>May 13, 1969</i>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 16, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>	
				23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR <i>GE Davis</i>		ADDRESS <i>Cunningham Funeral Home, Inc. Alex., Va.</i>		25a. REC'D BY REGISTRAR <i>DATE MAY 15 1969</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

03048

WILLIAM L. BROWN, JR.

FOR STATE  
HEALTH DEPT.

WILLIAM

WILLIAM L. BROWN, JR.

1



WILLIAM L. BROWN, JR.

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

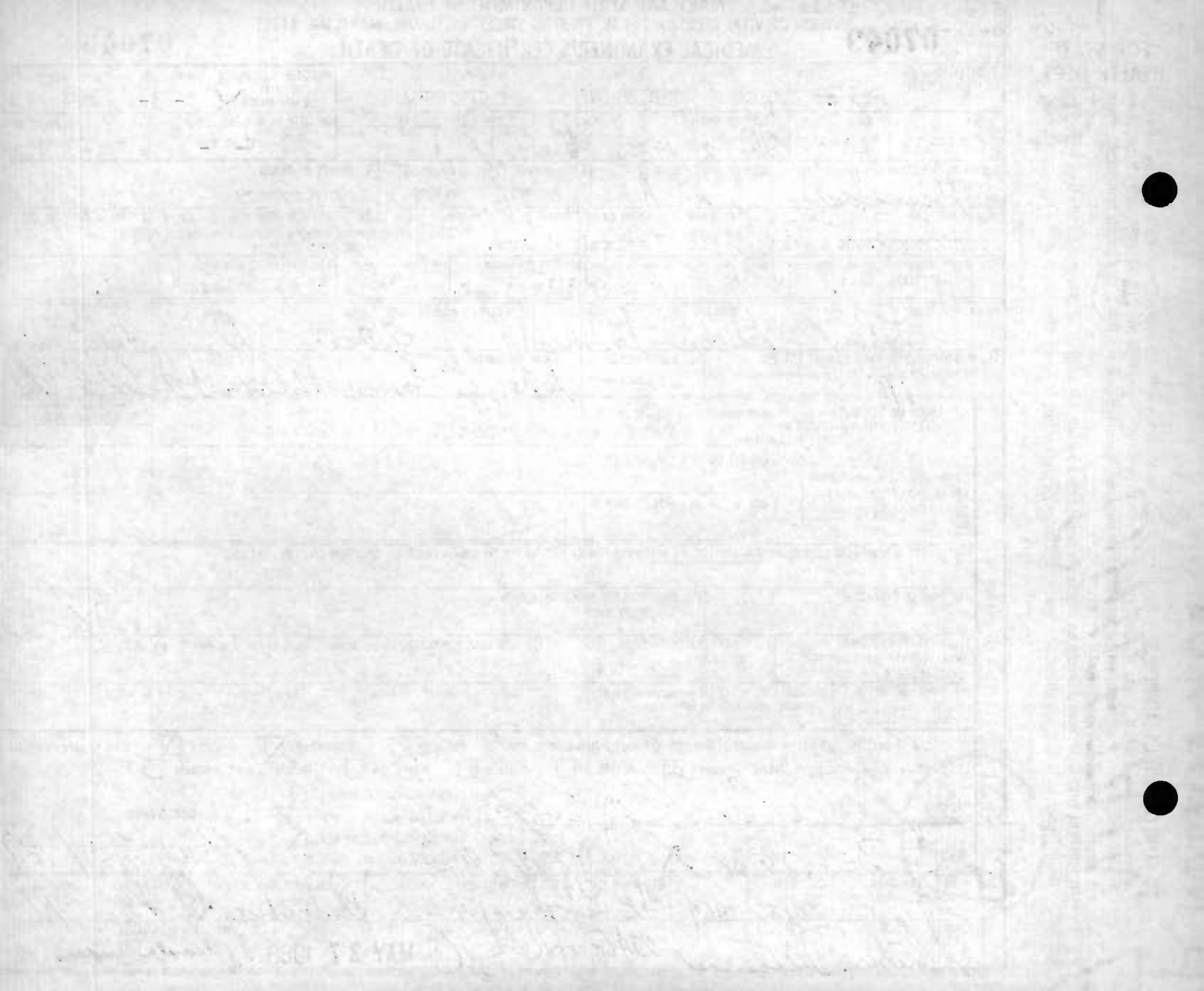
Items 18a, 22a, Film 413 MARYLAND STATE DEPARTMENT OF HEALTH  
6-12-63 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07045

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07045

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR
<del>UNKNOWN</del> ELOYCE CHRISTINA CRUICKSHANKS					5-23-1969		M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Female	White	Nov. 2-1922	46 YRS.			5-23-1969	3P M
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Brise Idaho	U.S.A.			Montgomery		Md.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver	216 Mississippi Ave.	Homemaker					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Md.	Montgomery	Silver Spr.		516 Mississippi Ave.			
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost
Lefoy	Edwin	Froom		Esther	B.	Taylor	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Lefoy E. Froom #6 Grace St. Silver Spr. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty metamorphosis of the liver</u> 571.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				2D. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		May 23, 1969	
Belden R. Bearup							
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
	May 16-1969	St. Lincoln		Baltimore Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Arthur Waters		254 Carroll St.		MAY 27 1969		Charles Judge	



1929

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
07050										
07046										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Gwendolyn Monier CRUMPACKER						May Month 13 Day Year 69		225A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		Caucasian		Sept. 13, 1910		58 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Washington, D.C.		USA				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Naval Hospital			housewife		N/A		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Virginia			Arlington		Arlington		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3717 North Nelson Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
John Henry BINSTED			Frances SMITH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
NO			577-46-9428		St. Arlington, Va. Address					
					RADM John W. CRUMPACKER, 3717 North Nelson					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1929 Glioblastoma multiforme DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Jan. 14, 1969, to May 13, 1969, that (I) (we) lost saw the deceased alive on May 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) Evans Diamond, M. D.							May 13, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		5/15/69		Arlington National Cemetery		Arlington, Arlington, Va.				
24. FUNERAL DIRECTOR Arlington Funeral Home					25. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
3901 North Fairfax Drive, Arlington, Va.					MAY 16 1969					

01020

STATE OF TEXAS

COUNTY OF DALLAS

IN SENATE

January 1, 1902

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE

FOR THE YEAR

ENDING DECEMBER

31, 1901

AND THE

REVENUE THEREFROM

FOR THE YEAR

ENDING DECEMBER

31, 1901

AND THE

REVENUE THEREFROM

FOR THE YEAR

ENDING DECEMBER

31, 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

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07051		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07047					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Blanche		none		Crystal				Month Day Year		12:00	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F		White		7-15-1903		65 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
New York		U. S. A.				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
TAKOMA PARK		Washington San & Hosp		Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Montgomery		Silver Spring				8500 New Hamp. Ave. S.S., md			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
		-		Jasper				=		Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				109-03-4707		Joseph Crystal		8500 New Hampshire Ave. #315 Silver Spring, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)		PREMORAL INTERVAL BETWEEN ONSET AND DEATH	
4100				Acute Myocardial Infarction.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)		Atherosclerotic Cardiovascular Disease.					
				(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				Hypertension							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 3-17, 1968, to 5-23, 1969, that (I) (we) last saw the deceased alive on 5-1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Morton A. Itschuler, M.D.		DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-23-69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Morton A. Itschuler, M.D.		7205-New Hampshire Ave. Silver Spring, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		May 25, 1969		King David Memorial Garden		Falls Church, Virginia					
24. FUNERAL DIRECTOR		Donald M. Stein		ADDRESS 232 Carroll		25a. REC'D BY REGISTRAR MAY 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			
Hebrew Memorial Funeral Home,		St., N.W. Wash.,		D.C.							

12050

2022-5-27-2022-5-28



4124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

69  
15  
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07052		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07048							
1. DECEASED-NAME (Type or print)			First JOHN	Middle HERBERT	Lost CUFF	2a. DATE OF DEATH Month 5 Day 19 Year 69		2b. HOUR P 3:10 M					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 12-11-79		6. AGE (In years last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.							
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY STORE							
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ASHTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER -					
14. FATHER'S NAME First MARTIN			Middle -		Last CUFF		15. MOTHER'S MAIDEN NAME First MARTHA			Middle -		Last Thompson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-32-2042			17. INFORMANT Address MEDICAL RECORD DEPT.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio-sclerotic cardiovascular disease</u> 15 yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs 6 wks 15 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from Jan 1939, to 1969, that (I) (we) lost saw the deceased alive on May 18 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE A. D. Bonifant						DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.						22e. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-23-69		23c. NAME OF CEMETERY OR CREMATORY Burtonville Union		23d. LOCATION (City or Town) Burtonville Mont.		(County) Md.		(State)			
24. FUNERAL DIRECTOR Francis H. Barber						ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR MAY 22 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

03004

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

DATE: 12-17-70 TIME: 10:10 AM

TO: DIRECTOR, FBI (100-442100)  
FROM: SAC, NEW YORK (100-100000) (P)  
SUBJECT: [REDACTED] (NY 100-100000)

RE: [REDACTED] (NY 100-100000)  
[REDACTED] (NY 100-100000)

THOMSON - [REDACTED] (NY 100-100000)  
[REDACTED] (NY 100-100000)

[REDACTED] (NY 100-100000)  
[REDACTED] (NY 100-100000)

[REDACTED] (NY 100-100000)  
[REDACTED] (NY 100-100000)

[REDACTED] (NY 100-100000)  
[REDACTED] (NY 100-100000)

[REDACTED] (NY 100-100000)  
[REDACTED] (NY 100-100000)

[REDACTED] (NY 100-100000)  
[REDACTED] (NY 100-100000)

THOMSON - [REDACTED] (NY 100-100000)  
[REDACTED] (NY 100-100000)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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4309

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Alexine P. David						May 11 1969		5:20 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		May 14 1917		51 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
South Carolina		U.S.A.				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Washington San. & Hosp.			Housewife		-----		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince George		Hyattsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5716 31st Avenue	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Donald F. Pence			Ila --- Boggan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			None		248-103786 William G. David same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra Cranial Hemorrh.</u> 4309 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture Cerebral Aneurysm</u> 4d. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Status post Craniotomy</u> 4d.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
5-7-69		Cerebral Aneurysm			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 5-4, 1969, to 5-11, 1969, that (I) (we) last saw the deceased alive on 5-10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Jonathan McWilliams M.D.</u>					22c. DATE SIGNED 5-11-69					
22d. PHYSICIAN'S NAME (Type) J. Williams M.D.					22e. ADDRESS 4835 Broad Brook Dr. Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		5/13/1969		Fort Lincoln Cemetery		Colmar Manor, Maryland				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Nalley's Funeral Home Mt. Rainier, Md.					MAY 14 1969		<u>Charles Jones</u>			

03053

CENTRAL OF FLA  
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Ad.

John C. ...

Ad.

John C. ...

Ad.

John C. ...

5-7-11 ...

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John C. ...

5-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

4109

2

07054

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07050

1. DECEASED-NAME (Type or print) <b>EUGENE COWAN DENSON</b>			2a. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1969</b>		2b. HOUR <b>1 A</b> M
3. SEX <b>Male</b> <del>XXXX</del>	4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 12, 1906</b>		6. AGE (In years lost birthday) <b>63</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>6208 Redwing Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Employee</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>Eugene</b> Middle <b>Grisham</b> Last <b>Denson</b>		15. MOTHER'S MAIDEN NAME First <b>Julia</b> Middle <b>McInnis</b> Last <b>McInnis</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>****</b>		16b. SOCIAL SECURITY NO. <b>579-42-8019</b>		17. INFORMANT <b>Helen W. Denson-Wife-</b> Address as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>with coronary sclerosis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>suddenly</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Had an acute myocardial infarction Feb 22, 1968</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>1949</b> , 19 <b>1949</b> , to <b>May 23, 1969</b> , that (I) (we) last saw the deceased alive on <b>May 23, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>C P Ryland</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5-29-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>4400-49 ST NW Washington DC 20006 C.P. RYLAND</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-31-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY,</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Montg. Co. Md.</b>		23e. REC'D BY REGISTRAR <b>JUN 5 1969</b>	
23f. REGISTRAR'S SIGNATURE <b>James Judge</b>		23g. ADDRESS <b>7557 Wisconsin Ave Bethesda, Md.</b>			



UNITED STATES OF AMERICA

RECEIVED AT THE NEW YORK OFFICE OF THE ATTORNEY GENERAL MAY 12 1936

EUGENE J. CONNOR DENSON

Male  
White

May 12, 1936

Mississippi U.S.A. X Montgomery

Business

0200 Rowling Road

Employed

Montgomery, Alabama X

0200 Rowling Road

0200

Business Bureau

Julia

Atlanta

\*\*\*\*

John E. Denson-alias-Address as above

UNITED STATES DEPARTMENT OF JUSTICE  
WASHINGTON, D.C.  
MAY 12 1936  
RECEIVED AT THE NEW YORK OFFICE OF THE ATTORNEY GENERAL  
MAY 12 1936



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07055

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07051

1. DECEASED-NAME (Type or print) <i>William T Diefenbach</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>25</i> Year <i>1969</i>		2b. HOUR <i>10:40 PM</i>
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>9/12/1892</i>		6. AGE (In years lost birthday) <i>76</i> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>New York</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hosp.</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Chemist</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Chemical.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Cherry Chase</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>4819 Leland St.</i>	
14. FATHER'S NAME First Middle Last <i>William Diefenbach</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Thilomena Servatius</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>	(If yes give war or dates of service) <i>****</i>	16b. SOCIAL SECURITY NO. <i>050-03-2698</i>	17. INFORMANT <i>Son &amp; Wife</i>		Address <i>Same</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i> <i>many years</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>68</i> , to <i>May</i> , 19 <i>69</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>May 6</i> , 19 <i>69</i> , and that in ( <del>my</del> ) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
22b. SIGNATURE <i>Allen J. O'Neill MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>5/25/1969</i>
22d. PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill</i>		22e. ADDRESS <i>8601 Old Georgetown Rd, Bethesda Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE <i>5-28-69</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Pr. Geo. Md.</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland.</i>		7557 <del>Woods</del> <i>Woods</i> <i>Scandin Ave.</i>		25a. REC'D BY REGISTRAR <i>JUN 2 1969</i>	25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>

STATE OF MICHIGAN

10

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

1929

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1-1-69

07056		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07052	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)		First (Rendleton) Middle Pedleton Last DUCKETT		2a. DATE OF DEATH May Month 25 Day Year 1969	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH May 26, 1925	
7a. BIRTHPLACE (State or foreign country) Wash. D. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U.S. Navy	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. COUNTY Alexandria		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Edmund Middle DuVal Last DUCKETT		15. MOTHER'S MAIDEN NAME First Eliza Middle Harrison Last		13d. STREET AND NUMBER 316 Lamond Place	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (No or unknown) Yes		16b. SOCIAL SECURITY NO. 1946-68		17. INFORMANT Mrs. Eliza Duckett, 2419 King St. Alexandria	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1929 Glioblastoma multiforme DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from Oct. 2, 1968, to May 25, 1969, that (X) (we) lost saw the deceased alive on May 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lawrence J. Mervis, M.D.				22c. DATE SIGNED May 27, 1969	
22d. PHYSICIAN'S NAME (Type) Lawrence J. Mervis, M.D.				22e. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/28/69		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
24. FUNERAL DIRECTOR Home, Alexandria, Virginia		ADDRESS ALEX. VA.		23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.	
25a. REC'D BY REGISTRAR DATE MAY 29 1969		25b. REGISTRAR'S SIGNATURE McDonald, Jr.			

43026

ORIGINAL  
1/10/10



1/10/10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07057

07053

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print) <i>Elizabeth N. Dungen</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>5</i> Day <i>31</i> Year <i>1969</i>			2b. HOUR <i>10 40 A M</i>				
3. SEX <i>F</i>	4. RACE <i>Wh</i>	5. DATE OF BIRTH <i>3-7-81</i>	6. AGE (In years last birthday) <i>88</i> YRS.	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>	2c. DATE PRONOUNCED DEAD Month <i>May</i> Day <i>31</i> Year <i>1969</i>				
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>				
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>1404 CROSS</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2101 Fairland Rd</i>		
14. FATHER'S NAME First <i>Robert</i> Middle <i></i> Last <i>Dixon</i>		15. MOTHER'S MAIDEN NAME First <i>Mary Jane</i> Middle <i>McGure</i> Last <i></i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. <i>215-54-7152</i>	
16c. ADDRESS <i>10500 Royal Rd</i>		17. INFORMANT <i>Frankie Garrison - Sil. Spring</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardio Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>years</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Fracture - Left Humerus + Left Hip</i>										
19a. DATE OF OPERATION <i>May 23 69</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Repair of Fracture - Hip</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <i>5/19 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) <i>Fell in nursing home</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Nursing Home</i>			21f. LOCATION Street or R.F.D. No. <i>2101 Fairland Rd</i>		City or Town <i>Silver Spring</i> County <i>Mont.</i> State <i>Md.</i>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John S. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>May 31, 1969</i>				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
			ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6-3-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Melrose</i>		23d. LOCATION (City or Town) <i>Northumberland</i> (County) <i>Pa.</i> (State) <i></i>				
24. FUNERAL DIRECTOR <i>Sanford's Home Mortuaries etc</i>				ADDRESS		25a. REC'D BY REGISTRAR <i>JUN 5 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William J. Indoo</i>		

7550





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

07058

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07054

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR <sup>p</sup>			
E.			Myrtle	Dunnebacke		May 26 1969			11:45 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
Female		White		12/23/89		79 YRS.		-- --		-- --		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Michigan		U.S.A.				Montgomery Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Olney			Brooke Grove Foundation			Housewife			Own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Montgomery		Silver Spring				405 Ellsworth Drive			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost	
George			Gauthier			Linnea			Ammesse			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT						Address	
No			None		Francis G. Dunnebacke						Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4379 DUE TO, OR AS A CONSEQUENCE OF										6 Mo		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)										2 1/2 Yrs		
DUE TO, OR AS A CONSEQUENCE OF										YES		
GENERALIZED ARTERIOSELEPOSIS												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
NONE												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from			FEB 26 May 1969			that (I) (we) last saw the deceased alive on 26 May 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE			D. R. LEWIS M.D.			22c. DATE SIGNED		27 May 69				
22d. PHYSICIAN'S NAME (Type)			D. R. LEWIS M.D.			22e. ADDRESS		700 CLOVELLY ST SIL. SPR. Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial			May 31, 1969		Catholic Cemetery		Marquette, Michigan					
24. FUNERAL DIRECTOR			C. G. Warner			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Warner E. Pumphrey, Inc.			8434 Georgia Avenue Silver Spring, Md.			JUN 2 1969		Charles Judge				

92078

712:11 22/11






TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <b>Elsie</b>			First <b>M.</b>			Middle <b>Durand</b>			Last			
2a. DATE OF DEATH <b>May 6 1969</b>			2b. HOUR <b>5:15 A.M.</b>									
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>8-22-1880</b>			6. AGE (in years last birthday) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <b>Montgomery</b>						
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Sylvan Manor Nursing Home</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>At Home</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Dist. of Col.</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2122 California At. N.W.</b>				
14. FATHER'S NAME <b>Watson</b>			First <b>Cline</b>			Middle <b>Emma</b>			Last <b>Clevenger</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>578-6049059</b>		17. INFORMANT <b>St. M., Wash., D.C.</b> <b>Mrs. Mildred McCormick, Daughter, 2122 Calif.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4123</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 1/2 years</b> <b>6 years</b> <b>years?</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 1</b> , 19 <b>63</b> , to <b>May 6</b> , 19 <b>69</b> , that (I) ( <b>we</b> ) last saw the deceased alive on <b>May 3</b> , 19 <b>69</b> , and that in (my) ( <b>our</b> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <b>we</b> ) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Neil P. Campbell</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5/6/69</b>				
22d. PHYSICIAN'S NAME (Type) <b>Neil P. Campbell</b>				22e. ADDRESS <b>1629 Cal Rd</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-9-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Suitland, Prince Georges Co. Md.</b>					
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SON, INC.</b>				25a. REC'D BY REGISTRAR <b>MAY 8 1969</b>			25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>					

07050

UNITED STATES OF AMERICA

NO. 100-100000-100000  
UNITED STATES OF AMERICA  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-100000-100000)  
FROM : SAC, NEW YORK (100-100000-100000)  
SUBJECT: [REDACTED]  
RE: [REDACTED]

DATE: 10-10-60  
CLASSIFICATION: [REDACTED]  
AUTHORITY: [REDACTED]

1. [REDACTED]  
2. [REDACTED]  
3. [REDACTED]

4. [REDACTED]  
5. [REDACTED]  
6. [REDACTED]

7. [REDACTED]  
8. [REDACTED]  
9. [REDACTED]

10. [REDACTED]  
11. [REDACTED]  
12. [REDACTED]

13. [REDACTED]  
14. [REDACTED]  
15. [REDACTED]

16. [REDACTED]  
17. [REDACTED]  
18. [REDACTED]

19. [REDACTED]  
20. [REDACTED]  
21. [REDACTED]

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last Joseph W Eason			2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOUR			
3. SEX Male			4. RACE White		5. DATE OF BIRTH 1-25-40		2c. DATE PRONOUNCED DEAD Month 5 Day 14 Year 1969		2d. HOUR 12:45 P.M.		
7a. BIRTHPLACE (State or foreign country) Anson Co N.C.			7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (In years last birthday) 29 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery								
10. CITY OR TOWN OF DEATH Takoma Pk			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7321 Carroll Ave			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Not known			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Takoma Pk			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last O. Z. Eason			15. MOTHER'S MAIDEN NAME First Middle Last Kettie Jones			13e. STREET AND NUMBER 7321 Carroll Ave					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or not known) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT (Name) Mrs. Kettie Eason			ADDRESS 607-Ray St. Pikesville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to 953X DUE TO, OR AS A CONSEQUENCE OF (b) Hanging, self-inflicted DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year 11:00 P.M. 5-14-69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) Deceased hang self from pipe in basement using belt from pants					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f. LOCATION Street or R.F.D. No. City or Town County State 7321 Carroll Ave. Takoma Pk. Montgomery Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Read			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED MAY 14 1969		
EXAMINER'S NAME (Type) BELDEN R. READ M.D.			ADDRESS 254 Carroll St.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS 254 Carroll St.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE May 18-1969			23c. NAME OF CEMETERY OR CREMATORY Graceland Family			23d. LOCATION (City or Town) County State Solma, Preston Md.		
24. FUNERAL DIRECTOR Charles Tatters			ADDRESS 254 Carroll St.			25a. REC'D BY REGISTRAR MAY 19 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

07000

WILSON'S CERTIFICATE OF DEATH

07000

WILSON'S CERTIFICATE OF DEATH





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07057

1. DECEASED-NAME (Type or Print) <i>Norman Kenneth Ebbs Jr</i>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <i>5 16 1969</i>			2b. HOUR <i>8:30</i> P.M.		
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>5/14/34</i>	6. AGE (in years lost birthday) <i>35</i> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD <i>May 16</i> Year <i>1969</i>		
7a. BIRTHPLACE (State or foreign country) <i>Hartford Conn</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Oceanographer</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Gaithersburg</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1912 Stedwick Dr.</i>
14. FATHER'S NAME First <i>Norman</i> Middle <i>Kennith</i> Last <i>Ebbs</i>			15. MOTHER'S MAIDEN NAME First <i>Jessie</i> Middle <i>W</i> Last <i>Wirth</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Korean</i>		16b. SOCIAL SECURITY NO. <i>047-486 30-0923</i>		17. INFORMANT <i>Norman Kenneth Ebbs Sr</i>		ADDRESS <i>53 Ridgewood W. Hartford Conn</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASphyxia-</i> <i>9520</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Carbon Monoxide Inhalation.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>15 min</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <i>5/16 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>ran over</i>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Street</i>		21f. LOCATION Street or R.F.D. No. <i>Blunt Rd. &amp; Neallsville Church Rd.</i> City or Town <i>Gaithersburg</i> County <i>Mont.</i> State <i>Md.</i>				
22a. I certify that I took charge of the remains described above, held on death resulted from: Naturol causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>								
ACTUAL SIGNATURE <i>John G Ball</i>		EXAMINER'S NAME (Type) <i>John G Ball</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED - <i>May 16, 1969</i>		
ADDRESS (Street, city, town, or county) <i>Bethesda, Md</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 19, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Soldiers Field Fairview Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>West Harford Conn.</i>		
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>				ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>		25a. REG'D BY REGISTRAR <i>May 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07062

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07058  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>Eileen Eddy</b>			2a. DATE OF DEATH Month Day Year <b>May 3 1969</b>		2b. HOUR <b>3:15 M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>5 March 1911</b>		6. AGE (In years last birthday) <b>58</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Missouri</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Virginia</b>		13b. COUNTY <b>Alexandria</b>	13c. CITY OR TOWN <b>Alexandria</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>5325 Polk Avenue</b>
14. FATHER'S NAME First Middle Last <b>Edgar O'Daniel</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Ruth Ritter</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>Not Available</b>		17. INFORMANT <b>Bethesda, Md. 20014</b> Address <b>The Medical Records, The Clinical Center</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia with Sepsis</b> <b>2050</b> DUE TO, OR AS A CONSEQUENCE OF <b>Shock Secondary to (A) and to</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Retroperitoneal Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Myelogenous Leukemia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Hours-Days</b> <b>4/7 - 5/2</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <b>Dr.</b> (this hospital) attended the deceased from <b>April 7, 1969</b> , to <b>May 3, 1969</b> , that <b>xx</b> (we) last saw the deceased alive on <b>May 3, 1969</b> , and that in <b>Dr.</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>xx</b> (we) (did) <b>did not</b> view the body after death.					
22b. SIGNATURE <b>Richard J. Samaha MD</b>				22c. DATE SIGNED <b>3 May 1969</b>	
22d. PHYSICIAN'S NAME (Type) <b>Richard J. Samaha, M.D.</b>				22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/4/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar</b>	
24. FUNERAL DIRECTOR <b>Greene Funeral Home, Alexandria, Va.</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 6 1969</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

29670

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 08-01-2010 BY 60322 UCBAW

[illegible]

1829

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07063										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07059																													
Item 11 Film 413 6/11/69 kk																														CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print) <b>MAMIE</b> <b>LELOIS</b> <b>ELLIOTT</b>															2a. DATE OF DEATH Month <b>30</b> Day <b>19</b> Year <b>1969</b>										2b. HOUR <b>11:00 PM</b>																								
3. SEX <b>FEMALE</b>										4. RACE <b>WHITE</b>										5. DATE OF BIRTH <b>JUNE 19, 1902</b>										6. AGE (In years last birthday) <b>66</b> YRS.					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>										7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH <b>MONTGOMERY</b>										Md.									
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>10927 Bucknell Drive</b>										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>										12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>										13b. COUNTY <b>MONTGOMERY</b>										13c. CITY OR TOWN <b>Silver Sp.</b>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER <b>10927 BUCKNELL DR. Silver Sp.</b>														
14. FATHER'S NAME <b>WILLIAM</b>										15. MOTHER'S MAIDEN NAME <b>MAMIE TITUS</b>																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>										(If yes give war or dates of service) <b>NONE</b>										16b. SOCIAL SECURITY NO. <b>223-01-0302</b>										17. INFORMANT <b>BURNELLE SORENSON</b>										Address <b>ARL VA. 1111 ARMY-NAVY DR</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of uterus (cervix)</b> <b>180X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years</b>																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from <b>January, 1969</b> , to <b>May 30, 1969</b> , that (I) (we) lost saw the deceased alive on <b>May 28, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE <b>Blaine H. Eig</b>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <b>May 30, 1969</b>																													
22d. PHYSICIAN'S NAME (Type) <b>BLAINE H. EIG</b>										22e. ADDRESS <b>9801 Design over Spring, Md.</b>																																							
23a. BURIAL/CREMATION, REMOVAL (Specify)										23b. DATE <b>JUNE 3, 1969</b>										23c. NAME OF CEMETERY OR CREMATORY <b>MAPLE VIEW CEM.</b>										23d. LOCATION (City or Town) (County) (State) <b>MARION KY</b>																			
24. FUNERAL DIRECTOR <b>IVES FUNERAL HOME</b>										ADDRESS <b>2847 WILSON BLVD ARL VA.</b>										25a. REC'D BY REGISTRAR <b>JUN 5 1969</b>										25b. REGISTRAR'S SIGNATURE <b>Richard Judge</b>																			



07083

NAME: JAMES  
 SEX: MALE  
 DATE OF BIRTH: MAY 20 1921  
 VISA: U.S.A.

PLACE OF BIRTH: SPRING  
 ADDRESS: 100  
 WILLIAM  
 DORIS  
 100-10-000

24 Jan  
 (name) (date) (time)

MALE  
 100-10-000  
 100-10-000  
 100-10-000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (1)  
30M REV. 7-58

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
07064												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR AM PM			
Harold			Joseph Elser			May 2 1969			3:25 M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Male		White		6 August 1907			61 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Wisconsin		USA					Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			The Clinical Center, NIH			Biologist			City Gov't.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Anne Arundel			Edgewater		YES		Route 3, Box 101		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last									
George Elser			Ella Fisher									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
Yes			1942-1945		Bethesda, Maryland The Medical Records, The Clinical Center,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2001</u> <u>arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lymphosarcoma (Widespread metastasis)</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 days</u> <u>8 Months</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (A) (this hospital) attended the deceased from <u>21 April</u> , 19 <u>69</u> , to <u>2 May</u> , 19 <u>69</u> , that <u>xx</u> (we) last saw the deceased alive on <u>2 May</u> , 19 <u>69</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>he</u> (we) (did) (do not) view the body after death.												
22b. SIGNATURE <u>David A. Bray MD</u>						22c. DATE SIGNED <u>2 May 1969</u>						
22d. PHYSICIAN'S NAME (Type) David A. Bray, MD.						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)						
Burial		5/5/69		Baltimore Nat'l		Baltimore		Md.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE						
Robert S. Benavente		6 1969		Severna Park		6 1969						

22050

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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07065

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07061

1. DECEASED-NAME (Type or Print) <i>Harry Vernon Embrey Jr.</i>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <i>May 6 1969</i>			2b. HOUR <i>8:35 PM</i>				
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>Jan. 25, 1919</i>	6. AGE (In years last birthday) <i>50 YRS.</i>	IF UNDER 1 YEAR MONTHS <i>3</i> DAYS <i>11</i>	IF UNDER 24 HRS. HOURS <i>8</i> MIN. <i>35</i>	2c. DATE PRONOUNCED DEAD Month <i>May</i> Day <i>6</i> Year <i>1969</i>			2d. HOUR <i>9:35 M.</i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.				
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Mechanic</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Whitehat</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>4507 Bayne St.</i>				
14. FATHER'S NAME First <i>Harry</i> Middle <i>Vernon</i> Last <i>Embrey Sr.</i>			15. MOTHER'S MAIDEN NAME First <i>Lottie</i> Middle <i>Burroughs</i> Last <i>Burroughs</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO. <i>1942-1945 220072093</i>		17. INFORMANT <i>Harry V. Embrey, Sr. father same # 13</i> ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema, acute</i> <i>5710</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Acute fatty metamorphosis, liver</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Alcoholism, acute and chronic</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>  <i>Years.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>May 7, 1969</i>				
EXAMINER'S NAME (Type) <i>John G. Ball</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
ADDRESS <i>17936 Old Georgetown Road, Bethesda, Montgomery, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5/9/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>			
24. FUNERAL DIRECTOR <i>Tyson Wheeler</i>				1331 R Rockville Pike Rockville, Maryland			25a. REC'D BY REGISTRAR DATE <i>MAY 9 1969</i>		25b. REGISTRAR'S SIGNATURE <i>John G. Ball</i>	

03063

RECEIVED - MEDICAL DEPARTMENT

UNITED STATES DEPARTMENT OF THE ARMY

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FOR STATE  
HEALTH DEPT.

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07066

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07062

1. DECEASED-NAME (Type or Print) <b>KIMBERLY</b>			First <b>DEAN</b> Middle <b>EVY</b> Last <b>DAWN</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>05</b> Day <b>12</b> Year <b>69</b>			2b. HOUR <b>M</b>				
3. SEX <b>Female</b>		4. RACE <b>Wh.</b>		5. DATE OF BIRTH <b>02/17/69</b>		6. AGE (In years last birthday) <b>27</b> YRS. <b>7</b> MONTHS <b>02</b> DAYS <b>25</b>		2c. DATE PRONOUNCED DEAD <b>5</b> Month <b>12</b> Year <b>69</b>			2d. HOUR <b>10:30</b> AM		
7a. BIRTHPLACE (State or foreign country) <b>Wash, DC</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>xxxxxxx minor</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Montgomery</b>				13c. CITY OR TOWN <b>Burntsville</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>3510 Fairland Rd, Brtn.</b>	
14. FATHER'S NAME <b>Roger Eugene Evy</b>				15. MOTHER'S MAIDEN NAME <b>Joe Anne Day</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS <b>Father, Roger-3510 Fairland Rd, Brtnsvl.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <b>Cardiorespiratory Failure</b>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>795 X</b>													
(b) <b>Cause Undetermined</b>													
DUE TO, OR AS A CONSEQUENCE OF													
(c) <b>(Crib Death) (SDTI)</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>													
ACTUAL SIGNATURE <b>Belden R. Keap</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>May 12, 1969</b>					
EXAMINER'S NAME (Type) <b>BELDEN R. KEAP M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, Town or county)									
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>May 14, 1969</b>				23c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>				23d. LOCATION (City or Town) (County) (State) <b>Falls Church, Virginia</b>	
24. FUNERAL DIRECTOR <b>J. Arthur Walters</b>				ADDRESS <b>254 Carrol NW WC</b>				25a. REC'D BY REGISTRAR <b>MAY 14 1969</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





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ugene

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Jon ••••

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father, •••

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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45M - 115

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07067											
CERTIFICATE OF DEATH											
07063											
1. DECEASED NAME (Type or print) First Middle Last HARRY Francis FANCHER					2a. DATE OF DEATH May Month 20 Day 1969 Year			2b. HOUR 3:08 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH August 8, 1890		6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Connecticut		7b. CITIZEN OF WHAT COUNTRY? America		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FOREMAN - NAVY YARD		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington D.C.		13b. COUNTY D.C.		13c. CITY OR TOWN D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4118 3rd Street, NW			
14. FATHER'S NAME First Middle Last Asa F FANCHER					15. MOTHER'S MAIDEN NAME First Middle Last Margaret TUTTLE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. (If give war or dates of service) 069-05-8698		17. INFORMANT Elizabeth J. Fancher <del>Robert Fancher</del> (Wife) same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from May 15, 1969, to May 20, 1969, that (I) (we) last saw the deceased alive on May 19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Arthur J. Wilets					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED May 20, 1969				
22d. PHYSICIAN'S NAME (Type) Arthur J. Wilets					22e. ADDRESS 1111 Spring, St. Silver Spring, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 23, 1969		23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		23d. LOCATION (City or Town) (County) (State) Hyattsville, Maryland					
24. FUNERAL DIRECTOR P. J. Smith, Silver Spring, Maryland Warner E. Pumphrey, Inc., 8434 Georgia Avenue					25a. REC'D BY REGISTRAR MAY 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

72056



11/10/1941

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07068

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07064

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
Morris Feinstein						5-26-69			19			9:55 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR			
M	W	9-18-15	53 YRS	MONTHS DAYS		HOURS MIN		5 26 1969			9:55 P.M.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Penn.		U. S. A.				Montgomery			Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring			Holy Cross			Pharmacist			Stautenberg					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Md.			Mont.			S. S.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1220 Eastwest Hwy.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Abraham Feinstein			Sarah --											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
						Hannah Feinstein, Wife, S.S., Md.			1220 E.W. Hghwy					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>White Coronary Insufficiency</u>														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Heart Disease</u>														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					21b. TIME OF INJURY Month, Day, Year					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
					19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Belden R. Reap</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22b. DATE SIGNED				
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					May 27, 1969				
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY				
Burial					5/28/69					Bnai Israel Cong. Cem.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Bernard Danzansky & Sons					3501 14th St. NW Wash., D.C.					JUN 2 1969				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07069									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Francis Marion			Fenwick			May 3 1969		2:35 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		5/8/14		59 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				Mont. Co.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Sil. Spg. Md.		Holy Cross		Foreman		Told Auto. Firm			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Mont.		Wheaton				3113 Medway St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Joseph A. Fenwick			Mattie Connelly						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
no			577-03-8844			Mrs. Margaret Fenwick, 3113 Medway Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Hemorrhage, gastric									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Carcinoma throat									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Gastric ulcer									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
3 days									
3 mos.									
9 mos.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSISTENT IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from July 1968, to May 3, 1969, that (I) (we) lost saw the deceased alive on May 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
A.W. Smith M.A.						5/3/69			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
A.W. SMITH						13018 GEORGIA AVE WHEATON, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 6, 1969		Cedar Hill Cemetery		Sutland, Maryland			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Warner E. Humphrey, Inc. 8434 Georgia Avenue Silver Spring, Md.						DATE MAY 7 1969		Charles Judge	

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UNITED STATES

3 days  
3 mos  
9 mos

~~Handwritten notes~~  
Handwritten notes  
Handwritten notes

88 May 3 69

Handwritten notes

A.W. SMITH  
A.W. SMITH JR.

13018 GEORGE AVE  
WHEATON, MD  
2/3/69



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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X

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) <b>Thomas nmn FERRARO</b>		2a. DATE OF DEATH Month <b>5</b> Day <b>8</b> Year <b>69</b>		2b. HOUR <b>2:45 AM</b>	
3. SEX <b>Male</b>	4. RACE <b>Caus</b>	5. DATE OF BIRTH <b>4/7/84</b>	6. AGE (In years last birthday) <b>85</b> YRS.	IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>1</b>	IF UNDER 24 HRS HOURS <b>1</b> MIN <b>1</b>
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Wheaton, Md</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Home University Nursing</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Brick layer</b>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>DC</b>	13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Washington</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>509 Massachusetts Ave NW</b>	
14. FATHER'S NAME First <b>FERRARO</b> Middle <b>Un KNOWN</b> Last <b>Un KNOWN</b>	15. MOTHER'S MAIDEN NAME First <b>Un KNOWN</b> Middle <b>Un KNOWN</b> Last <b>Un KNOWN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT <b>Nursing Home Records - Wheaton, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>probable myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>chronic</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Pneumonia</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State <b>Quincy 69 Quincy 69</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>Quincy 69</b> , 19 <b>69</b> , to <b>Quincy 69</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>May 19, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>David A. Morawitz, M.D.</b>		DEGREE <b>MD</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <b>DAVID A. MORAWITZ, M.D.</b>		22e. ADDRESS <b>9237 Three Oaks Drive, Silver Sp Md.</b>		22c. DATE SIGNED <b>May 1969</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>MAY 10, 1969</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CONGRESSIONAL Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON D.C.</b>		
24. FUNERAL DIRECTOR <b>James E. Nyson</b>		ADDRESS <b>Wash. D.C.</b>	25a. REC'D BY REGISTRAR <b>MAY 12 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner

07071												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												07067											
1. DECEASED-NAME (Type or print) First Middle Last Helen DELORES Finch												2a. DATE OF DEATH Month Day Year 5 15 69												2b. HOUR 3:30AM											
3. SEX Female				4. RACE CAUCASIAN				5. DATE OF BIRTH 7-11-24				6. AGE (In years last birthday) 44 YRS.				IF UNDER 1 YEAR MONTHS DAYS 10				IF UNDER 24 HRS. HOURS MIN 10															
7a. BIRTHPLACE (State or foreign country) MD				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md.																							
10. CITY OR TOWN OF DEATH Kensington				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens 3000 McCOMAS AVE				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD				13b. COUNTY MONT				13c. CITY OR TOWN Rockville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER 13313 VANDALIA DR																			
14. FATHER'S NAME First Middle Last Calvin Wolfe				15. MOTHER'S MAIDEN NAME First Middle Last GRAY																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO. 577-26-1351				17. INFORMANT Lorenzer J. D. Finch, Sr. Husband same Address #13313																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 340X IMMEDIATE CAUSE (a) Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF Multiple sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs 6 years																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item f8.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (I) (this hospital) attended the deceased from 4/1/65, 19, to 5/15, 1969, that (I) (we) lost saw the deceased alive on 4/30/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE Patrick C. Jameson M.D. DEGREE												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 5/15/69																			
22d. PHYSICIAN'S NAME (Type) Patrick C. Jameson												22e. ADDRESS 11718 Georgia Silver Spring Md.																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 5/19/69				23c. NAME OF CEMETERY OR CREMATORY Parklawn				23d. LOCATION (City or Town) (County) (State) Rockville, Montg. Md.																							
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home Rockville, Md.												25a. REC'D BY REGISTRAR MAY 19 1969				25b. REGISTRAR'S SIGNATURE Charles Judge																			

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Female  
Caucasian  
July 24  
44-10

Кремль

3000 W. 2nd St. #200  
Kalamazoo, MI 49001

44200

[illegible]

Wolfe

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[illegible]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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07068

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <i>Calvin Harvey Fitz Sr.</i>		2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <i>May 4 1969</i>		2b. HOUR <i>10:20</i>
3. SEX <i>M</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>Nov. 14-24 1945</i>	6. AGE (In years and months) <i>24 YRS.</i>	7. COUNTRY <i>U.S.A.</i>
7a. BIRTHPLACE (State or foreign country) <i>N.C.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Sudburton</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Bus Driver</i>
13a. USUAL RESIDENCE (Where deceased lived) <i>Maryland</i>		13b. CITY OR TOWN <i>Clarksburg</i>		13c. STREET AND NUMBER <i>Route Box 98B</i>
14. FATHER'S NAME <i>Fitz Calvin</i>		15. MOTHER'S MAIDEN NAME <i>Alice Lewis</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Gene V. Fitz</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> <i>9520</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carbon Monoxide Poisoning</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>None</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hr.</i> <i>1/2 hr.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <i>9 P.M. 5/4 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) <i>in garage. Part here from exhaust pipe in rear window of car</i>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home garage</i>		21f. LOCATION Street or R.F.D. No. City or Town County State <i>Route I Box 98. Clarksburg. Montgomery Md.</i>
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John S. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>May 4, 1969</i>
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5/10/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>John Wesley Cemetery</i>
		23d. LOCATION (City or Town) (County) (State) <i>CLARKSBURG, Montg. Md.</i>		
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i>		ADDRESS <i>Rockville, Md.</i>		25a. REC'D BY REGISTRAR <i>MAY 8 1969</i>
		25b. REGISTRAR'S SIGNATURE <i>Volunteer Judge</i>		



25050



2532

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
07073										
CERTIFICATE OF DEATH										
07069										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Patricia			Maureen			FLINN		May Month 20 Day 1969 920A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		Caucasian		August 29, 1957		11 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
N. Carolina		USA				Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Naval Hospital			N/A		N/A		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Virginia			Pr. William		Woodbridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20 Williamsburg Court	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
John D. Flinn			Jean Turner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
N/A			N/A		John D. Flinn, 20 Williamsburg Court, Woodbridge, Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) 1943 Brain edema									1 week	
DUE TO, OR AS A CONSEQUENCE OF (b) Malignant pituitary chromophobe adenoma									2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (X) (this hospital) attended the deceased from May 8, 1969, to May 20, 1969, that (X) (we) last saw the deceased alive on May 20, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
C. B. EARLY									May 21, 1969	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
C. B. EARLY, M.D.					Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		23 May 69		Arlington National		Arlington Arlington Va.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Cunningham-Mountcastle Funeral Home, Woodbridge, Virginia					MAY 23 1969		Charles Judge			

5050

1. The first group of people who are not in the labor force are those who are not in the labor force because they are not in the labor force.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07074

07070

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <u>ROGER</u> First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <u>May 11 1969</u> 2b. HOUR <u>11:50</u> M		
3. SEX <u>M.</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>12/21/149</u>	6. AGE (In years last birthday) <u>19</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS	UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <u>New York</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Student</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Chesapeake</u>	
14. FATHER'S NAME First Middle Last <u>ROGER G. Flynn</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>Edith M. Cecil</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>8190</u>		17. INFORMANT ADDRESS <u>Father - Roger Flynn Dr</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion -</u> <u>8190</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Destruction of Frontal Lobes of Brain</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Trauma from Auto Accident</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>10 Mo.</u> <u>10 Mo.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <u>11:30 P.M. July 12 1968</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>During car involved in accident</u>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Street</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>Riverside Burdette Bethesda Montgomery Md</u>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <u>May 12, 1969</u>	
EXAMINER'S NAME (Type) <u>John G Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <u>Bethesda, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 14, 1969</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Gabriels</u>		23d. LOCATION (City or Town) (County) (State) <u>Potomac Montgomery Md</u>	
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>		25a. REC'D BY REGISTRAR <u>May 19 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

25050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1268

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First <b>THOMAS</b>			Middle <b>HENRY C.</b>			Last <b>FLYNN</b>		
2a. DATE OF DEATH			Month <b>5</b> Day <b>2</b> Year <b>69</b>			2b. HOUR <b>9:10A</b>			M		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>5-24-83</b>			6. AGE (In years last birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b>					
10. CITY OR TOWN OF DEATH <b>OLNEY</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MONTGOMERY GENERAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>			
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>DAMASCUS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>24929 RIDGE ROAD</b>			
14. FATHER'S NAME First <b>ZACKERY T.</b>			Middle <b>FLYNN</b>			15. MOTHER'S MAIDEN NAME First <b>ROSA</b>			Middle <b>LEE</b> Last <b>SMITH</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-56-1895</b>			17. INFORMANT <b>MEDICAL RECORD DEPT.</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced Arteriosclerotic Cardiovascular Disease</b>										Years	
DUE TO, OR AS A CONSEQUENCE OF <b>Generalized Arteriosclerosis</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>No accident</b>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>April 17, 1969</b> , to <b>May 2, 1969</b> , that (I) ( <del>we</del> ) lost saw the deceased alive on <b>May 2, 1969</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.											
22b. SIGNATURE <i>M. McKendree Boyer</i>						22c. DATE SIGNED <b>May 2, 1969</b>		22d. PHYSICIAN'S NAME (Type) <b>M. MCKENDREE BOYER, M.D.</b>			
22e. ADDRESS <b>9701 CHURCH ST., DAMASCUS, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 4, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Upper Seneca Baptist</b>		23d. LOCATION (City or Town) (County) (State) <b>Cedar Grove, Md.</b>					
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>						25a. REC'D BY REGISTRAR <b>MAY 6 1969</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

07013

CRIMINAL RECORD

NAME: JAMES E. HENRY, JR. DATE: 1-1-61

SEX: MALE RACE: WHITE  
DOB: 1-1-24-24 BIRTHPLACE: ALABAMA  
EDUCATION: HIGH SCHOOL GRAD  
OCCUPATION: LABORER  
MARRIAGE: SINGLE  
RELIGION: CATHOLIC  
MILITARY SERVICE: NONE  
REMARKS: DATA

1-1-24-24

REMARKS: ADVANCE FOR RECORD - THIS RECORD IS FOR THE YEAR 1961

NOTE

MAY 2, 1961

STATE OF ALABAMA, COUNTY OF ...

NOTARY PUBLIC, ...

MAY 2, 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
MAY			L.		FRIEDMAN	MAY Month 1 Day 1969 Year		45 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
male		white		10-20-00		68 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Poland		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring			Holy Cross			Upholstering		Upholstering	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
D.C..						Washington		13e. STREET AND NUMBER	
								1416 Ogelthorpe St.N.W	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Louis			Friedman			Gitel ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
No						WIFE			
						MRS. REBECCA FRIEDMAN - AS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> <u>15 hr</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>68</u> , to <u>APRIL</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>30 APRIL</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Ira N. Tublin</u>					22c. DATE SIGNED <u>5/1/69</u>				
22d. PHYSICIAN'S NAME (Type) <u>IRA N. TUBLIN</u>					22e. ADDRESS <u>MD 800-PERSHING DR. SILVER SPRING, MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>BURIAL</u>		<u>5-2-69</u>		<u>ELESABETERAD CEM.</u>		<u>WASHINGTON DC</u>			
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY</u>					25a. REC'D BY REGISTRAR <u>MAY 6 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		
<u>430NS-WASH-DC.</u>									

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END

74-100-1-17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 45M (4)  
5-1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
07077									
07073									
1. DECEASED-NAME (Type or print) First Middle Last <i>Anna May Gamage</i>			2a. DATE OF DEATH Month Day Year <i>May 19, 1969</i>			2b. HOUR <i>4:55 PM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>11/14/1920</i>		6. AGE (In years last birthday) <i>48 1/4</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Home maker</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md. Montgomery</i>		13b. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4501-Fairfield Dr.</i>			
14. FATHER'S NAME First Middle Last <i>Ervin Todd</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Lane Jackson</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>579-12-0698</i>		17. INFORMANT <i>John Williams</i>		Gamage		Address <i>11908 Reynolds Ave. Rockville</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma rothphagus et</i> <i>150X</i> DUE TO, OR AS A CONSEQUENCE OF <i>metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>16</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>8-3</i> , 19 <i>69</i> , to <i>5-19</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5-19</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>V.C. deGuzman</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5-20-69</i>		
22d. PHYSICIAN'S NAME (Type) <i>VICENTE C. DE GUZMAN</i>					22e. ADDRESS <i>1234 19th St NW WASH D.C.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5/22/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Maryland</i>			
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>					ADDRESS <i>Rockville, Md.</i>		RECD. BY REGISTRAR <i>May 22 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07078		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07074	
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
James Lawrence Gardner, Sr.				May 8 1969		1:00 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Male		White		6 March 1919		50 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Pennsylvania		USA				Montgomery Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		The Clinical Center, NIH		Laborer		Aircraft Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Pennsylvania		Clinton		Beech Creek		Locust Street	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last			
Raymond Gardner				Lula Council			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT			
Yes		1943-1945		Bethesda, Maryland 20014 The Medical Records, The Clinical Center,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure							Terminal
398X DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Rheumatic Heart Disease							20 Years
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Chronic Myelogenous Leukemia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7 May 1969, to 8 May 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8 May 1969, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
						8 May 1969	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
Michael B. Mosher, M.D.				The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		5-11-69		Highland Cemetery		Liberty Twp, Centre, Pa.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Bruce A. Bechler, Beech Creek, Pa.				MAY 13 1969		Charles Judge	

MEDICAL CERTIFICATION



James Lawrence Gardner, Jr. 8 1963

State Police USA

Investigative

Technical The Clinical Center, NIH

Investigative

General

Director, National Institute of Health, Bethesda, Md.

Investigative

Investigative

Investigative

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151  
45M - 1-69

07079		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07075		
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Annie Estelle GERMANN					Month Day Year May 31 1969		M	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	December 19, 1894			74 YRS.	MONTHS DAYS	HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Annecl. Maryland	U.S.			Montgomery				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Kensington -	Kensington Gardens Nursing Home.			Housewife		None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
Maryland	Montgomery	Bellevue Spring	YES <input type="checkbox"/> NO <input type="checkbox"/>	2408-Dennis Avenue.				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Robert	Earl			Matilda Scaggs				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
		217-14-7125		Ernest Germann		Athane		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion few min. DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) diabetes mellitus & obesity years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Rheumatoid arthritis & crippling Parkinson's disease								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Feb 7, 1969, to May 1, 1969, that (I) (we) last saw the deceased alive on 4-29-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		
John R. Spencer M.D.		5-1-69		John R. Spencer		5-1-69		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5-5-69	Union Cemetery		Baltimore Md			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Donaldson Funeral Home		Baltimore Md		May 6, 1969		James Judge		

07079

RECEIVED DECEMBER 1941

UNITED STATES DEPARTMENT OF AGRICULTURE

07079

Handwritten notes and signatures, including a large signature at the bottom left.

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**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07080

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07076

1. DECEASED-NAME (Type or Print) <u>Bradley</u> First <u>Monroe</u> Middle <u>Gerwig</u> Last			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <u>5</u> Day <u>7</u> Year <u>1969</u>			2b. HOUR <u>3:10</u> PM	
3. SEX <u>MALE</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>7/20/17</u>	6. AGE (In years last birthday) <u>51</u> YRS.	IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u>	IF UNDER 24 HRS. HOURS <u>  </u> MIN. <u>  </u>	2c. DATE PRONOUNCED DEAD Month <u>5</u> Day <u>7</u> Year <u>1969</u>	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.	
10. CITY OR TOWN OF DEATH <u>Gaithersburg</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>DOA Suburban Hospital</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Guard</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD.</u>			13b. COUNTY <u>Frederick</u>			13c. CITY OR TOWN <u>Frederick</u>	
14. FATHER'S NAME First <u>Harry</u> Middle <u>T.</u> Last <u>Gerwig</u>			15. MOTHER'S MAIDEN NAME First <u>Daisy</u> Middle <u>Bazzell</u> Last <u>  </u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16b. SOCIAL SECURITY NO. <u>W.W. 2 216-16-5695</u>			17. INFORMANT ADDRESS <u>Mrs. Ruby Gerwig Frederick, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109 Coronary Occlusion.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Arterio Sclerosis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>  </u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>  </u> P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>May 8, 1969</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <u>Montgomery County</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>5-10-1969</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	
23d. LOCATION (City or Town) <u>Frederick, Maryland</u>			23e. REC'D BY REGISTRAR <u>MAY 16 1969</u>			23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. FUNERAL DIRECTOR <u>Robert E. Dailey &amp; Son</u> ADDRESS <u>Frederick, Md.</u>							

03070

RECORDS OF THE DEPARTMENT OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07081		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07077	
1. DECEASED-NAME (Type or print) First Middle Last <i>William T. Gibb</i>			2a. DATE OF DEATH Month Day Year <i>May 10 1969</i>			2b. HOUR <i>11:30</i>	
3. SEX <i>MALE</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>5-9-1902</i>		6. AGE (In years last birthday) <i>67</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>New York City</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Physician</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Kennington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>William T. Gibb</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Alice Stearns</i>		13e. STREET AND NUMBER <i>9700 West Bexhill Dr</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or date of service) <i>yes WW-II</i>		16b. SOCIAL SECURITY NO. <i>220-44-6206</i>		17. INFORMANT Address <i>Dr. S. Peter Gibb - son</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) 1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i> <i>6 mo.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Status post gastrectomy for Carcinoma of Stomach</i>							
19a. DATE OF OPERATION <i>Dec 1968</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>11 May 1968</i> to <i>11 May 1969</i> , that (I) (we) last saw the deceased alive on <i>11 May 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John P. ...</i>		22c. DATE SIGNED <i>12 May 69</i>		22d. PHYSICIAN'S NAME (Type) <i>JOHN P. ...</i>			
22e. ADDRESS <i>4977 Ballymore Blvd NW</i>		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>5/13/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ROCK CREEK CEMETERY</i>		23d. LOCATION (City or Town) (County) (State) <i>WASHINGTON, D.C.</i>	
24. FUNERAL DIRECTOR <i>Kerry E. ...</i>		25a. REC'D BY REGISTRAR <i>MAY 14 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William Judge</i>			



07082

CENTRAL OF DEATH

07082



5/13/58

10/2

10/2

WASHINGTON, D.C.

ROCK OCEAN CEMENTERY

5/13/58

BURIAL

MARTIN W. HYSON CO. 1300 N. STREET, N.W. - WASH. D.C.



174X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07082		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07078			
1. DECEASED-NAME (Type or print) First Middle Last Loel MINI Gilbert						2a. DATE OF DEATH Month Day Year 5 14 69		2b. HOUR 2:50 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12-3-36		6. AGE (In years last birthday) 32 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) La.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md.		13b. COUNTY montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3718 THORNAPPLE ST.	
14. FATHER'S NAME First Middle Last L. RICHARD HASPEL		15. MOTHER'S MAIDEN NAME First Middle Last HERMINA MOOG							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. —		17. INFORMANT PAUL R. GILBERT - SAME AS #13		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Breast Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of Breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>29VS</u> 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>69</u> , to <u>5/14</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/13</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE G. Leonard Gold				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/14/69			
22d. PHYSICIAN'S NAME (Type) G. LEONARD GOLD				22e. ADDRESS 9801 GEORGIA AVE, SL. SPR. MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL TRANSIT		23b. DATE 5/16/69		23c. NAME OF CEMETERY OR CREMATORY GARDEN OF MEMORIES		23d. LOCATION (City or Town) (County) (State) JEFFERSON PARISH, LOUISIANA			
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS, 5130 WISCONSIN AVE. N.W., WASHINGTON, D.C.				25a. REC'D BY REGISTRAR DATE MAY 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



1538

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07083		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07079					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Leif</i>			Middle <i>Gilstad</i>		Lost <i>Gilstad</i>		2a. DATE OF DEATH Month <i>May</i> Day <i>17</i> Year <i>1969</i>		2b. HOUR <i>1:05</i> PM		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>10/20/1915</i>		6. AGE (In years last birthday) <i>73</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>TRANSPORTATION</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD. DC</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>5300 Westover Lane Beth.</i>			
14. FATHER'S NAME First <i>Lewis</i> Middle <i>Gilstad</i> Last <i>Gilstad</i>			15. MOTHER'S MAIDEN NAME First <i>Rina</i> Last <i>Houelshrud</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>412-01-7923</i>		17. INFORMANT Address <i>Wife, Josephine M. Gilstad.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma colon with metastasis</i> <i>1538</i> DUE TO, OR AS A CONSEQUENCE OF <i>To Smaller Intestine, Liver, Adrenal &amp; Lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Coronary Arteriosclerosis and emphysema</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>January 19</i> to <i>17 May, 1969</i> , that (I) (we) last saw the deceased alive on <i>17 May 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>A. Richwine</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>May 19 1969</i>	
22d. PHYSICIAN'S NAME (Type) <i>A. RICHWINE</i>		22e. ADDRESS <i>5322 WESTOVER AVE CHEVY CHASE, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal-Burial</i>		23b. DATE <i>5-20-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lakewood Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Minneapolis, Minnesota</i>					
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SON, INC.</i> 5130 WISC. AVE., N. W. WASH., D. C. 20016					25a. REC'D BY REGISTRAR <i>MAY 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

05050

4109  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07084											
Item #13c.e, Film G413 6/2/69 km											
CERTIFICATE OF DEATH											
07080											
1. DECEASED-NAME (Type or print) <i>Sadie</i>			2a. DATE OF DEATH Month <i>5</i> Day <i>23</i> Year <i>69</i>			2b. HOUR <i>5 AM</i>					
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>8-4-87</i>			6. AGE (In years last birthday) <i>86</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>md.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) <i>Holy Cross</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Silver Spring</i>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
14. FATHER'S NAME <i>John E. Graham</i>			15. MOTHER'S M maiden NAME <i>Alice Leizear</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>Mrs. Betty Mandley</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1967</i> to <i>MAY 23 1969</i> , that (I) ( <i>we</i> ) last saw the deceased alive on <i>23 MAY 1969</i> , and that in (my) ( <i>our</i> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <i>we</i> ) ( <i>and</i> ) (did not) view the body after death.											
22b. SIGNATURE <i>Walter E. Goosz</i>			22c. DATE SIGNED <i>5/24/69</i>			22d. PHYSICIAN'S NAME (Type) <i>Walter E. Goosz</i>					
22e. ADDRESS <i>2309 Shorefield Rd., Wheaton, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>			23b. DATE <i>May 26, 1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln</i>			23d. LOCATION (City or Town) (County) (State) <i>Bladensburg, Md.</i>		
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey Inc.</i>			25a. REC'D BY REGISTRAR <i>MAY 27 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

07081

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

REPORT OF THE SECRETARY OF AGRICULTURE

FOR THE YEAR 1908

IN RESPONSE TO A RESOLUTION OF THE HOUSE OF REPRESENTATIVES

PASSED MAY 1, 1908

AND A RESOLUTION OF THE SENATE

PASSED MAY 1, 1908

RELATIVE TO THE INVESTIGATION OF THE

CAUSES OF THE DROUGHT IN THE

WESTERN STATES OF THE UNITED STATES

IN 1907 AND 1908

AND THE EFFECTS THEREOF

ON THE AGRICULTURE OF THE UNITED STATES

AND THE WELFARE OF THE PEOPLE

OF THE UNITED STATES

IN 1907 AND 1908

AND THE EFFECTS THEREOF

ON THE AGRICULTURE OF THE UNITED STATES

AND THE WELFARE OF THE PEOPLE



1621  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
2  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07085		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07081	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Le Roy</i>		First		Middle		Lost	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>10/1/88</i>		2a. DATE OF DEATH Month <i>may</i> Day <i>24</i> Year <i>69</i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (In years lost birthday) <i>80</i> YRS.	
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Potomac Valley Hosp. Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Gaithersburg</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <i>Robert</i>		First		Middle		Lost	
15. MOTHER'S MAIDEN NAME <i>Margaret</i>		First		Middle		Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>718-14-9561</i>		17. INFORMANT <i>Leroy Glenn</i>		Address <i>Gaithersburg Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>1621</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma left lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>1-2 yrs</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct</i> , 1968, to <i>5-24</i> , 1969, that (I) ( <del>was</del> ) last saw the deceased alive on <i>5-24</i> , 1969, and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) (did) ( <del>did not</del> ) view the body after death.							
22b. SIGNATURE <i>W. G. Hall</i>		22c. DATE SIGNED <i>5/24/69</i>		22d. PHYSICIAN'S NAME (Type) <i>W. G. Hall</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5-27-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>National Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Falls Church Va</i>	
24. FUNERAL DIRECTOR <i>Ernest C. Gortner</i>		ADDRESS <i>1001 ... Gaithersburg, Md</i>		25a. REC'D BY REGISTRAR <i>DATE MAY 28 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

07082

1969 8 27 10:00 AM

## 07086

VR A15 (4)  
45M - 1/69

32678

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07087		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07083				
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		Month	Day	Year	2b. HOUR
Joseph William GORMAN					May 9 1969					1:00aM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	Caucasian		9 November 1910		58 YRS.	MONTHS		DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Penna.	U.S.A.				Montgomery		Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda, Maryland	Naval Hospital		Retired							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
FLORIDA	Escambia		PENSICOLA		1509 N.R ST.					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Sister-in-law		Address		
Yes				Mrs. Ruby Barney		Same as Item 13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent carcinoma, base of tongue										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (a) (this hospital) attended the deceased from 11 Feb, 1969, to 9 May, 1969, that (x) (we) lost saw the deceased alive on 9 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Robert P. Majors Jr. MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10 MAY 1969		
22d. PHYSICIAN'S NAME (Type) Robert P. Majors, MD				22e. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-12-69		23c. NAME OF CEMETERY OR CREMATORY Barrancas Natl Cem.		23d. LOCATION (City or Town) (County) (State) Pensacola, Florida				
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				ADDRESS		25a. REC'D BY REGISTRAR MAY 15 1969		25b. REGISTRAR'S SIGNATURE Pumphrey, Robert		

78050

17 JAN 1951



15719

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07088										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07084														
1. DECEASED-NAME (Type or print) <b>First LOUIS Middle JOHN Last GOUCHER</b>										2a. DATE OF DEATH <b>May</b> Month <b>28</b> Day <b>1969</b> YRS.										2b. HOUR <b>7:25P</b> M.														
3. SEX <b>Male</b>					4. RACE <b>Caucasian</b>					5. DATE OF BIRTH <b>April 22, 1897</b>					6. AGE (In years last birthday) <b>72</b> YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>					7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>					B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>Montgomery</b> Md.																			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>US Navy Retired</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>					13b. COUNTY <b>Anne Arundel</b>					13c. CITY OR TOWN <b>Annapolis</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <b>1206 Van Buren Drive</b>														
14. FATHER'S NAME <b>Charles</b>					14. FATHER'S NAME <b>John</b>					14. FATHER'S NAME <b>GOUCHER,</b>					15. MOTHER'S MAIDEN NAME <b>Honora</b>					15. MOTHER'S MAIDEN NAME <b>McAULLIFE</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>WWI &amp; WWII</b>										16b. SOCIAL SECURITY NO. <b>577-44-2173</b>					17. INFORMANT <b>Rose E. GOUCHER (Wife)</b> Address <b>1206 Van Buren Drive, Annapolis, Maryland</b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> <b>1519</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 20</b> , 19 <b>69</b> , to <b>May 28</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 28</b> , 19 <b>69</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.															22b. SIGNATURE <b>D. K. ROEDER, LCDR MC USN</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. DATE SIGNED <b>29 May 1969</b>																			
22d. PHYSICIAN'S NAME (Type) <b>D. K. ROEDER, LCDR MC USN</b>										22e. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>																								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE <b>6-2-69</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>					23d. LOCATION (City or Town) (County) (State) <b>Arlington Fairfax Va.</b>																			
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS FUNERAL HOME,</b>										24. FUNERAL DIRECTOR <b>3072 M Street, N.W., Washington, D. C.</b>										25a. REC'D BY REGISTRAR <b>JUN 4 1969</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-222a Film 413 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) <b>Thomas James Gowen Sr</b>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>5</b> Day <b>8</b> Year <b>1969</b>		2b. HOUR <b>6:49A</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>3-16-19</b>	6. AGE (in years lost birthday) <b>50</b> YRS.	7c. DATE PRONOUNCED DEAD Month <b>5</b> Day <b>8</b> Year <b>1969</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Amer U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9a. COUNTY OF DEATH <b>Montgomery</b>		10. CITY OR TOWN OF DEATH <b>Takoma Pk</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington San &amp; Hospital FOREMAN</b>
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>INDUSTRY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>VEHICLE FACTORY</b>		13a. STREET AND NUMBER <b>1927 Red Oak Dr</b>
13b. COUNTY <b>PRINCE GEORGES</b>		13c. CITY OR TOWN <b>Adelphi</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <b>Joseph</b> Middle <b>Patrick</b> Last <b>Gowen</b>		15. MOTHER'S MAIDEN NAME First <b>Grace</b> Middle <b>Burch</b> Last <b>Burch</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>
16b. SOCIAL SECURITY NO. <b>220 059396</b>		17. INFORMANT <b>MRS. DORIS M. GOWEN</b>		ADDRESS <b>SAME AS #13</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>412.3 Acute coronary insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Belden R. Reap</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>MAY 8, 1969</b>
EXAMINER'S NAME (Type) <b>BELOEN R. REAP, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>MAY 10, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEM</b>
23d. LOCATION (City or Town) <b>COLMAR MANOR, MARYLAND</b>		23e. REC'D BY REGISTRAR <b>MAY 14, 1969</b>		23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO. RIVERDALE, MD</b>				

02750

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07086

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Joyce H. GRANGER			2a. DATE OF DEATH Month Day Year May 3 69			2b. HOUR 215P M					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH August 20, 1898		6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) W. Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Bethesda, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Alexandria		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6405 16th Street			
14. FATHER'S NAME First Middle Last Theodore George FRUM			15. MOTHER'S MAIDEN NAME First Middle Last Eliza Verde Dorson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 228-40-9163		17. INFORMANT Address Mrs. Stanley F. Rollin, 1905 Oren Dr. Laurel, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from <u>May 1</u> , 19 <u>69</u> , to <u>May 3</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>May 3</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Douglas L. Horton, M.D.</u>					DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED May 5, 1969		
22d. PHYSICIAN'S NAME (Type) Douglas L. Horton, M. D.					22e. ADDRESS Naval Hospital, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-7-69		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery			23d. LOCATION (City or Town) (County) (State) Arlington Va.				
24. FUNERAL DIRECTOR Everly-Wheatley					ADDRESS Funeral Home, 1500 W. Braddock, Alexandria, Va.		25a. REC'D BY REGISTRAR MAY 8 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

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07091

07087

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			<input type="checkbox"/> Month	Day	Year	2b. HOUR	
Eugene Alston Green Jr.						MAY 4 1969						3 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR		
M.	W.	APRIL 1, 1947		22 YRS.	MONTHS DAYS		HOURS MIN.		MAY Day 8 Year 1969		5 PM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Va.		U.S.A.				Montgomery Md.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Near Cabin John.				Potomac River				STUDENT					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Va.				Arlington		Alexandria		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6410 South Van Dorn St.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
Eugene				ALSTON	GREEN JR.	MERLE				BRASWELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO			228-66-1398			MOTHER			SAME AS ABOVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:												5 PM '69	
IMMEDIATE CAUSE (a) Drowning =													
9100 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) 2 hours swimming in Potomac River													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
				3 PM 5-4 1969				Swimming in River suddenly sank					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
				Potomac River				Sandy Landings Widewater Great Falls Fairfax Va.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED	
EXAMINER'S NAME (Type)				JOHN G. BALL				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				MAY 8, 1969	
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
								ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
MAY 12, 1969				MAY 12, 1969		POWICK CEMETERY				POWICK FAIRFAX Va.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
TYSON WHEELER F.H.				ROOKVILLE MARYLAND				MAY 12 1969				Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
07092									
07088									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Edward Bryan Grimes						5-4-69			215 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		10-11-96		72 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring			Belpre Health Center			Carpenter			building
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER (rural)
Md.			Howard		West Friendship		NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Bazzell Grimes			Mary Tasker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
?			219-01-2227		Helen Grimes 1801 Bonifant Rd., Silver Springs, Md. 20906				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Pulmonary Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchial Neoplasm</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>4-20-</u> , 19 <u>69</u> , to <u>5-4-</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>5-4-</u> , 19 <u>69</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Rafael C. Inclan</u> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>May 4, 1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>RAFAEL C. INCLAN</u>					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/7/69		Higginbotham		Ellicott City, Md. Md.			
24. FUNERAL DIRECTOR <u>Higginbotham Slack</u>					25a. REC'D BY REGISTRAR DATE <u>MAY 8 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

<p>1. Name of the person or organization to whom the check is payable</p>		<p>2. Amount in figures</p>	
<p>3. Amount in words</p>		<p>4. Date</p>	
<p>5. Signature of the person or organization issuing the check</p>		<p>6. Bank or financial institution</p>	
<p>7. Branch name</p>		<p>8. Address</p>	
<p>9. City</p>		<p>10. State</p>	
<p>11. Zip code</p>		<p>12. Telephone number</p>	
<p>13. Remarks</p>		<p>14. Other information</p>	

07093

CERTIFICATE OF DEATH

07089

1. DECEASED-NAME (Type or print) <i>Bessie Gertrude Gurn</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>17</i> Year <i>1969</i>		2b. HOUR M
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Dec. 27, 1881</i>		6. AGE (In years last birthday) <i>87</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Chicago, Illinois</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Oak Haven Nursing Home</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Musical Teacher</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Teaching</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Takoma Park</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>7906 Takoma Avenue</i>	
14. FATHER'S NAME First Middle Last <i>Samuel O. Bracken</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Bertha Delange</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes, give branch and dates of service) <i>no</i>		16b. SOCIAL SECURITY NO. <i>336-01-6377</i>	17. IN <i>Montgomery</i> <i>Lewisdale, Md.</i> Address <i>James McLean (Dan) 2303 Drexel Street</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Artery Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>4 years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>May 1, 1952</i> to <i>May 17, 1969</i> , that (I) (we) last saw the deceased alive on <i>May 10, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Frank S. Bacon</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>May 17, 1969</i>
22d. PHYSICIAN'S NAME (Type) <i>Frank S. Bacon</i>				22e. ADDRESS <i>2141-K- Street NW Washington, DC</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	23b. DATE <i>May 20, 1969</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Forest Home</i>	23d. LOCATION (City or Town) (County) (State) <i>Forest Park, Illinois</i>		
24. FUNERAL DIRECTOR <i>Warner O. Pumphrey, Inc.</i>		ADDRESS <i>8434 Ga. Ave. Sil Spg. Md.</i>	25a. REC'D BY REGISTRAR <i>MAY 20 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
Ruth H. Haberman						Month Day Year			5:47 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Female	White	12/15/04	64 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year	5:47 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington D.C.		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park			Washington San. + Hosp.			Resident manager			Apt. House
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland			Prince George's			Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
John Hurley			Blanche Elberly			2213 University Blvd. Apt 104 E			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS
no			578 09 1212			W.S.H. Hospital Records			Takoma Park Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Acute Myocardial Infarction									
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
Belden R. Reap M.D.						May 2, 1969			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (City, town, or county)			
Belden R. Reap M.D.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		5/16/69		Glenwood		Washington D.C.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Francis Gasch's Sons Hyattsville, Md.					MAY 7 1969		Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
07095					CERTIFICATE OF DEATH					07091							
1. DECEASED NAME (Type or print)			First <i>Frances</i>			Middle <i>B.</i>			Last <i>Hackett</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>16</i> Year <i>1969</i>			2b. HOUR <i>4:30</i> M		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>5-24-1896</i>			6. AGE (In years last birthday) <i>72</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <i>New Jersey</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.								
10. CITY OR TOWN OF DEATH <i>Wheaton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>			13b. COUNTY <i>Montgomery</i>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>10817 Madison St.</i>								
14. FATHER'S NAME First <i>John</i>			Middle <i>Burleigh</i>			Last <i>Anna</i>			15. MOTHER'S MAIDEN NAME First <i>Anna</i>					Middle <i>Heighton</i>		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>579-42-9342-A</i>			17. INFORMANT <i>Mrs. Edward Schaefer,</i>					Address <i>Kensington, Md.</i>		10817 Madison St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA OF THE BREAST</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>35 yrs</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>CARCINOMA OF THE STOMACH</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <i>about</i> , 19 <i>66</i> , to <i>5/16</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5/16</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Richard H. Pollen</i> MD			22c. DATE SIGNED <i>5/16/69</i>			22d. PHYSICIAN'S NAME (Type) <i>RICHARD H. POLLEN</i>											
22e. ADDRESS <i>10400 CONNECTICUT AVE KENSINGTON</i>																	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>May 20, 1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>St. Peters Catholic Cem</i>			23d. LOCATION (City or Town) (County) (State) <i>Merchantville, Pennsylvania</i>								
24. FUNERAL DIRECTOR <i>C. Glen Carter</i>			434 <i>Georgia Avenue</i>			25a. REC'D BY REGISTRAR <i>Warner E. Pumphrey, Inc. Silver Spring, Md.</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			DATE <i>MAY 20 1969</i>					

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DEPT. OF AGRICULTURE

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "DEPT. OF AGRICULTURE" and "BUREAU OF PLANT INDUSTRY" are faintly visible.]*

*[Vertical text on the right margin, likely bleed-through from the reverse side.]*

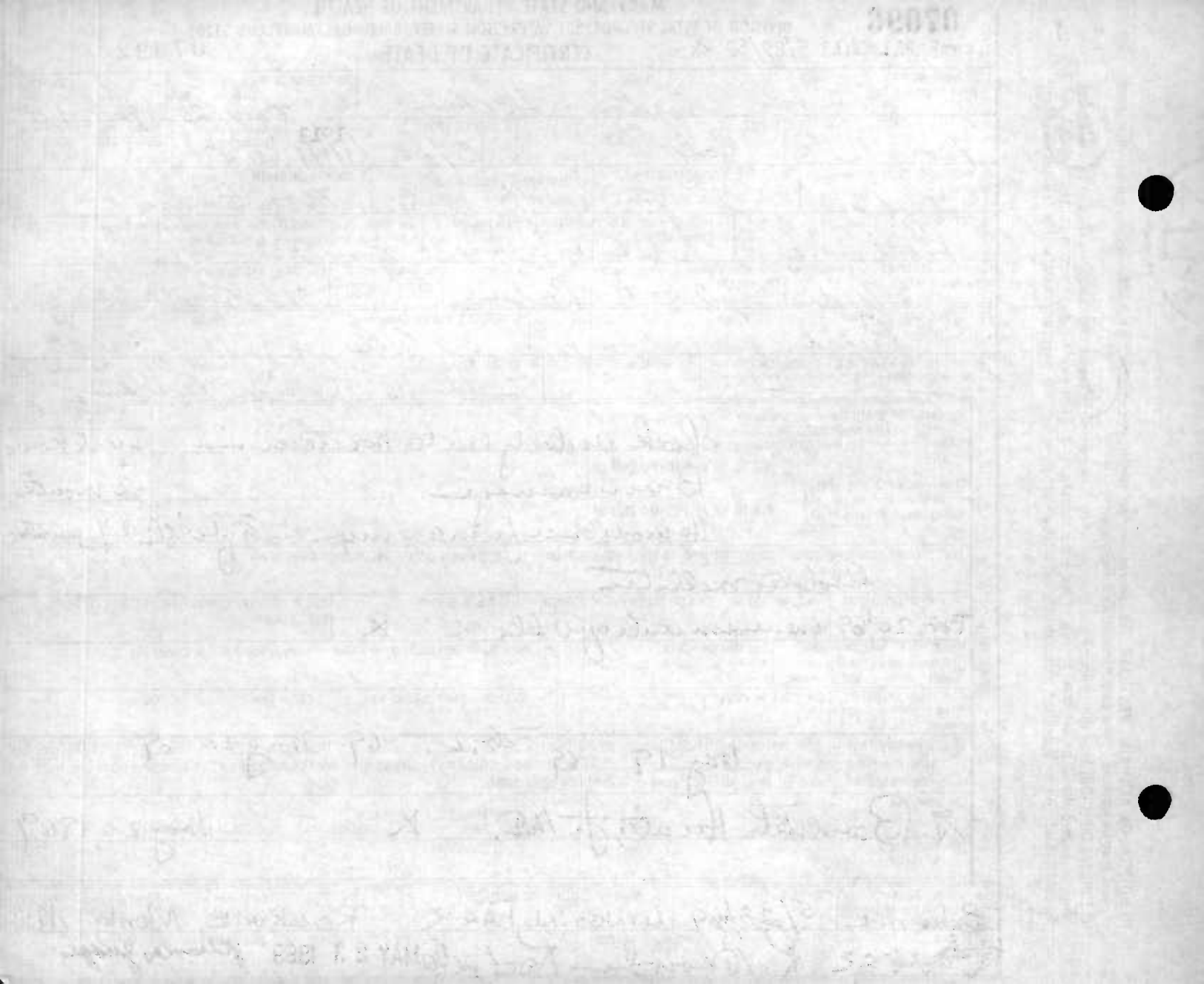
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07096		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07092	
Item 5 Film 413 5/29/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) First Middle Last Emma Loretta Hochney			2a. DATE OF DEATH Month Day Year May 20 1969		2b. HOUR 11:30 M
3. SEX Female	4. RACE Cal	5. DATE OF BIRTH 3/15/1913		6. AGE (in years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Mont	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 316 Lincoln Ave
14. FATHER'S NAME First Middle Last Richard Leroy			15. MOTHER'S MAIDEN NAME First Middle Last Lillie Pratt		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	17. INFORMANT Address same as above Husband Joseph Hochney		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock probably due to bacteremia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Brain damage DUE TO, OR AS A CONSEQUENCE OF (c) Hemorrhage from aneurysm, circle of Willis. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes mellitus					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4309 2 months 2 1/2 months
19a. DATE OF OPERATION Feb. 20 '69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED aneurysm circle of Willis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1969, to May 20, 1969, that (I) (we) last saw the deceased alive on May 19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Bonville Hunter, Jr. MD		22c. DATE SIGNED May 20, 1969		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/23/69		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park	
24. FUNERAL DIRECTOR George R. Snowden		25a. REC'D BY REGISTRAR MAY 23 1969		25b. REGISTRAR'S SIGNATURE Johnas Judge	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 3 14  
45M 11 69

07097

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07093

1. DECEASED-NAME (Type or print) First Middle Last Thomas Wesley HARTLEY			2a. DATE OF DEATH Month Day Year May 25 1969			2b. HOUR 11:48 M					
3. SEX Male		4. RACE CAUC.		5. DATE OF BIRTH 10/29/93		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN. & HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CAB DRIVER				12b. KIND OF BUSINESS OR INDUSTRY TAXI			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 256 PARK AVE.			
14. FATHER'S NAME First Middle Last JOHN HARTLEY			15. MOTHER'S MAIDEN NAME First Middle Last SUSAN HARRIS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If give war or dates of service) 571-48-3750		17. INFORMANT Address HOSPITAL RECORD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 6 ± Bleeding 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PROBABLE MESENTERIC INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) POSSIBLE PANCREATIC CANCER APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 HOURS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from MAY 18, 1969, to MAY 25, 1969, that (I) (we) last saw the deceased alive on MAY 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Gene U. Cohen M.D.					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-25-1969				
22d. PHYSICIAN'S NAME (Type) GENE U. COHEN					22e. ADDRESS 1106 SPRING ST. SILVER SPRING, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-29-69		23c. NAME OF CEMETERY OR CREMATORY WASH. NAT. CEM			23d. LOCATION (City or Town) (County) (State) SUITLAND MD				
24. FUNERAL DIRECTOR W.W. Chambers Co					ADDRESS 1400 Capitol St. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR DATE MAY 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

07007

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

TO: [Illegible]  
FROM: [Illegible]  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report with several paragraphs.]

Very truly yours,  
[Illegible Signature]  
[Illegible Title]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07098

07094

FOR STATE  
HEALTH DEPT.

1. DECEASED-NAME (Type or Print) <i>Ellen Clarissa Hask</i>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> 5 19 1969			2b. HOUR 12:30 M		
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Feb 7, 1969</i>	6. AGE (in years last birthday) <i>3</i> YRS. <i>10</i> MONTHS <i>10</i> DAYS	IF UNDER 24 HRS. <input type="checkbox"/> HOURS <input type="checkbox"/> MIN		2c. DATE PRONOUNCED DEAD <i>May 19</i> 1969		2d. HOUR <i>11:15</i> M
7a. BIRTHPLACE (State or foreign country) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Infant</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1012 Paul Dr.</i>
14. FATHER'S NAME <i>Frank Delano Hask</i>			15. MOTHER'S MAIDEN NAME <i>Ruth Turner</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		
16b. SOCIAL SECURITY NO.			17. INFORMANT <i>Matthew</i>			17. ADDRESS <i>Same as above</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> <i>911X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Aspiration of Gastric Contents</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>37M17</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <i>12:30 AM 5/19 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Aspirated food taken about 1/2 hr after eating</i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>1012 Paul Dr. Rockville</i>		21f. LOCATION City or Town <i>Montgomery</i> State <i>Md.</i>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>May 19, 1969</i>		
EXAMINER'S NAME (Type) <i>John G. Ball</i>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>May 19, 1969</i>		
23a. BURIAL, CREMATION, <i>Burial</i>			23b. DATE <i>5/20/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montgomery, Md.</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>			ADDRESS <i>1331 Rock Pike Rockville, Maryland</i>			25a. REC'D BY REGISTRAR <i>Charles J. Jones</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMS-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

29055

FOR STATE  
HEALTH DEPT.

07099

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07095

1. DECEASED-NAME (Type or Print)		First James F.		Middle Hassett		Last Sr.		2a. DATE KNOWN OF ESTI- DEATH MATED		Month 5-14		Day 19		Year 1969		2b. HOUR 10:30			
3. SEX male		4. RACE cac		5. DATE OF BIRTH 7/17/95		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month May		Day 14		Year 1969			
7a. BIRTHPLACE (State or foreign country) Wash, DC		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH St. Montg.													
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bricklayer				12b. KIND OF BUSINESS OR INDUSTRY -							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md				13b. COUNTY Howard				13c. CITY OR TOWN Ellicott City				13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				13e. STREET AND NUMBER 6604 Allen Lane			
14. FATHER'S NAME First Michael				Middle ?				Last Hassett				15. MOTHER'S MAIDEN NAME First Bridget				Middle ?			
Last Shae				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16b. SOCIAL SECURITY NO. (If yes give year or dates of service) W. W. I				17. INFORMANT ADDRESS 9218-St.				James F. Hassett Jr. - Andrews Pl.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>with Heart Block</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> 4123																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Belden R. Keap						CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22b. DATE SIGNED May 14, 1969							
EXAMINER'S NAME (Type) BELDEN R. KEAP						ADDRESS (Street, city, town or county) Mt. Rainier, Maryland													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 5/17/69				23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.				23d. LOCATION (City or Town) (County) (State) Wash., D.C.							
24. FUNERAL DIRECTOR Valley's Funeral Home Inc.						ADDRESS Mt. Rainier, Maryland						25a. REC'D BY REGISTRAR DATE MAY 19 1969							
25b. REGISTRAR'S SIGNATURE William J. Jones																			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

22650



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH					
First Middle Last Frederick William Heine					Month Day Year May 26 1969					2b. HOUR 6 <sup>35</sup> AM
3. SEX Male		4. RACE White		5. DATE OF BIRTH January 20, 1893		6. AGE (In years last birthday) 76 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Dist. of Columbia		7b. CITIZEN OF WHAT COUNTRY? U.S. America		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington San + Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Real Estate Sales		12b. KIND OF BUSINESS OR INDUSTRY Real Estate				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 311 Lanark Way		
14. FATHER'S NAME First Middle Last Frederick Heine			15. MOTHER'S M maiden name First Middle Last Emma Simpers			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO				
16b. SOCIAL SECURITY NO. 577-18-4679			17. INFORMANT Fred W. Heine, 111 Address P.O. Box 9705 Southerland Rd., Silver Spring, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Anteroseptal Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 TWO DAYS SEVERAL YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes Mellitus</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>5-15</u> , 19 <u>69</u> , to <u>5-26</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-25</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Stuart L. Nelson</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5-26-69</u>				
22d. PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>				22e. ADDRESS <u>831 Univ. Blvd. East. Silver Spg. Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 29, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Mont., Maryland</u>				
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 3 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07101

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07097

1. DECEASED-NAME (Type or Print)		First James		Middle Albert		Last Herbert		2a. DATE KNOWN OF DEATH		Month 5		Day 20		Year 1969		2b. HOUR 9:05 AM			
3. SEX M		4. RACE W		5. DATE OF BIRTH 9-1-93		6. AGE (In years last birthday) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 5 Day 20 Year 1969		2d. HOUR 9:05 AM					
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery													
10. CITY OR TOWN OF DEATH Takoma Park, Md.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San & Hosp				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED				12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9302 Adelphi Rd. Adelphi, Md.									
14. FATHER'S NAME First John Middle Franklin Last Herbert				15. MOTHER'S MAIDEN NAME First Addie Middle Sarah Last Dean Herbert															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Army				16b. SOCIAL SECURITY NO. 1st W. War 220-44-2365		17. INFORMANT sister Mrs. A. Blair				ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency																			
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerotic Heart Disease																			
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION																19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Belden R. Reap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED MAY 20, 1969							
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS Street, City, Town, County											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 5/23/69				23c. NAME OF CEMETERY OR CREMATORY Mt. OLIVET				23d. LOCATION (City or Town) (County) (State) WASH., D.C.							
24. FUNERAL DIRECTOR JAS. T. RYAN, Inc. 317 PA. AVE., S.E. WASH., 20002, D.C.								25a. REC'D BY REGISTRAR DATE MAY 23 1969				25b. REGISTRAR'S SIGNATURE Charles Judge							

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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07098				
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or Print)			First LEON		Middle M.		Last HERMAN		2a. DATE KNOWN OF DEATH Month Day Year 5 31 1969		2b. HOUR 3:00 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1/26/05		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year May 31 1969		2d. HOUR 4:25 PM		
7a. BIRTHPLACE (State or foreign country) Poland			7b. CITIZEN OF WHAT COUNTRY? U. S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery			Md.		
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Economist			12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Sp.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10027 Brunett Ave.				
14. FATHER'S NAME First Middle Last Jacob Herman				15. MOTHER'S MAIDEN NAME First Middle Last Mollie --										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Augusta Herman				ADDRESS Sil. Sp, Md. 10027 Brunett Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4124</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.			City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John G. Ball John G. Ball						M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED May 31, 1969		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/3/69		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gar.				23d. LOCATION (City or Town) (County) (State) Falls Church, Va.						
24. FUNERAL DIRECTOR Bernard Danzansky & Sons						ADDRESS -3501 14th St. N.W. Wash., D.C. 20010		25a. REC'D BY REGISTRAR JUN 5 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07103		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07099	
Items 11 & 16		Film 413 6/4/69 kk		CERTIFICATE OF DEATH	
1. DECEASED-NAME (Type or print) First Middle Last <b>Leo Ingemann Highby</b>			2a. DATE OF DEATH Month Day Year <b>MAY 18 1969</b>		2b. HOUR <b>11A M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>11/30/01</b>		6. AGE (In years lost birthday) <b>67</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Minn.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>America</b>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Grosvener La. Nur. Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>State Dept. Official</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Bethesda</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>5702 Aberdeen Rd.</b>
14. FATHER'S NAME First Middle Last <b>Lars P. Highby</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Anna Hansen</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>578-32-4097M</b>		17. INFORMANT Address Same as above <b>Mrs. Elizabeth P. Highby - wife</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4379 Bronchial pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>with Brain Atrophy</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>year</b> <b>year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT</b> , 19 <b>68</b> , to <b>MAY</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>5 16</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Sarah E. Glover M.D.</b>				22c. DATE SIGNED <b>5-18-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>SARAH E. GLOVER M.D.</b>				22e. ADDRESS <b>10128 CEDAR LAKE Kensington Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-21-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Rockville, Montg. Md.</b>		23e. REC'D BY REGISTRAR <b>Charles Judge</b>		23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Md.</b>					

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above subject.

The matter is being considered and a reply will be made as soon as possible.

Very respectfully,  
 [Signature]

STANDARD FORM NO. 64

Enclosed for you are two copies of the report of the Board of Inquiry into the circumstances surrounding the death of [Name] on [Date].

The report contains a detailed account of the events leading up to the tragedy and the findings of the Board.

I am sure that you will find this information of interest and value.

Very truly yours,  
 [Signature]

Very truly yours,  
 [Signature]

Enclosed for you are two copies of the report of the Board of Inquiry into the circumstances surrounding the death of [Name] on [Date].

The report contains a detailed account of the events leading up to the tragedy and the findings of the Board.

I am sure that you will find this information of interest and value.

Very truly yours,  
 [Signature]

4124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-60)  
30M REV. 1/60

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
07100																	
1. DECEASED-NAME (Type or print)			First <b>CLAUDE</b>			Middle <b>NMN</b>			Last <b>HOBBS</b>			2a. DATE OF DEATH Month <b>5</b> Day <b>22</b> Year <b>69</b>			2b. HOUR <b>9:10A</b>		
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>7-12-83</b>			6. AGE (In years last birthday) <b>85</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>MONTGOMERY</b>								
10. CITY OR TOWN OF DEATH <b>OLNEY</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CATTLE DEALER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>LIVESTOCK</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>			13c. CITY OR TOWN <b>SILVERSPRING</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>13309 SHERWOOD FOREST DRIVE</b>					
14. FATHER'S NAME First <b>FRANKLIN</b>			Middle <b>-</b>			Last <b>HOBBS</b>			15. MOTHER'S MAIDEN NAME First <b>MARTHA</b>			Middle <b>-</b>			Last <b>JOHNSON</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>578-48-6305</b>			17. INFORMANT Address <b>MEDICAL RECORD DEPT.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Apoplexy, thrombotic</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Anterior subarachnoid hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 Months</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)						21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>65</b> , to <b>May</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>5/22</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>A. D. Bonifant</b>												DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M. D.</b>												22e. ADDRESS <b>MEDICAL CENTER, SANDY SPRING, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>5-26-69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Colesville</b>			23d. LOCATION (City or Town) (County) (State) <b>Colesville Mont. Md.</b>								
24. FUNERAL DIRECTOR ADDRESS <b>Francis H. Barber Laytonsville, Md.</b>												25a. REC'D BY REGISTRAR DATE <b>MAY 26 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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James B. Cooper, Jr., Secretary

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07105

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07101

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) <b>Hazel Hill</b>			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>5-12-69</b>			2b. HOUR <b>1:25 P.M.</b>		
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>1-27-1898</b>	6. AGE (In years last birthday) <b>71</b> YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>5</b> Month <b>12</b> Year <b>1969</b>			2d. HOUR <b>1:25 P.M.</b>		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>					
10. CITY OR TOWN OF DEATH <b>Takoma Park,</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash San &amp; Hosp</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b># 8 Travis Dr. T.P., Md.</b>		
14. FATHER'S NAME <b>George</b> First Middle Last			15. MOTHER'S MAIDEN NAME <b>Kate</b> First Middle Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					
16b. SOCIAL SECURITY NO.			17. INFORMANT <b>John V. Roberts</b>			ADDRESS <b>17506 1700 Farm Dr.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Belden R. Neap</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>May 12, 1969</b>			
EXAMINER'S NAME (Type) <b>BELDEN R. NEAP, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City, Town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>May 15-1969</b>				23c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>			
24. FUNERAL DIRECTOR <b>Arthur Waters</b>				ADDRESS <b>354 Carroll St - DC</b>				25a. REC'D BY REGISTRAR <b>May 15 1969</b>			
								25b. REGISTRAR'S SIGNATURE <b>Arthur Waters</b>			

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07106

## CERTIFICATE OF DEATH

07102

1. DECEASED-NAME (Type or print) <i>William K Hodges</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>1</i> Year <i>1969</i>			2b. HOUR M <i></i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>5/16/08</i>		6. AGE (In years last birthday) <i>66</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Wash D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Supervisor</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Telephone</i> Co			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Kensington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>10225 Kensington Pkwy</i>	
14. FATHER'S NAME First <i>Louis</i> Middle <i>O</i> Last <i>Hodges</i>			15. MOTHER'S MAIDEN NAME First <i>Ethel</i> Middle <i></i> Last <i>Keebus</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <i></i>			17. INFORMANT <i>Wife Maureen Hodges</i>			Address <i>Same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Coronary arteriosclerosis with thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <i>April 16</i> , 19 <i>69</i> , to <i>May 1</i> , 19 <i>69</i> , that (I) ( <i>we</i> ) last saw the deceased alive on <i>MAY 1</i> , 19 <i>69</i> , and that in (my) ( <i>our</i> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <i>we</i> ) ( <i>did</i> ) ( <i>did not</i> ) view the body after death.									
22b. SIGNATURE <i>Joseph P. Connor, M.D.</i>				22c. DATE SIGNED <i>May 2, 1969</i>					
22d. PHYSICIAN'S NAME (Type) <i>JOSEPH P. CONNOR</i>				22e. ADDRESS <i>9420 OLD GEORGETOWN RD.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5-5-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville Mont Md</i>			
24. FUNERAL DIRECTOR <i>Robert A Pumphrey Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR <i>MAY 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

87105

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words are difficult to discern but appear to include:]*

*[...]* **PLANT INDUSTRY** *[...]*  
*[...]* **UNITED STATES** *[...]*  
*[...]* **DEPARTMENT OF AGRICULTURE** *[...]*  
*[...]* **BUREAU OF PLANT INDUSTRY** *[...]*  
*[...]* **WASHINGTON, D. C.** *[...]*  
*[...]* **1910** *[...]*  
*[...]* **PLANT INDUSTRY** *[...]*  
*[...]* **UNITED STATES** *[...]*  
*[...]* **DEPARTMENT OF AGRICULTURE** *[...]*  
*[...]* **BUREAU OF PLANT INDUSTRY** *[...]*  
*[...]* **WASHINGTON, D. C.** *[...]*  
*[...]* **1910** *[...]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>07107</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 5 Film 412 5/12/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>07103</div>											
1. DECEASED-NAME (Type or print) <i>Anna Pauline Holdridge</i>						2a. DATE OF DEATH Month <i>May</i> Day <i>4</i> Year <i>1969</i>			2b. HOUR <i>5:45 P M</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>July 18, 1911</i>			6. AGE (In years last birthday) <i>74</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.				
10. CITY OR TOWN OF DEATH <i>Wheaton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Nursing Home Randolph D.H.S.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Librarian</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov.</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Brookeville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>-</i>	
14. FATHER'S NAME First <i>Eugene</i> Middle <i>Holdridge</i> Last <i>Holdridge</i>			15. MOTHER'S MAIDEN NAME First <i>Anna</i> Middle <i>Johnson</i> Last <i>Johnson</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO. <i>220-44-4099-T</i>			17. INFORMANT Address <i>Mrs. Alexander Casanges Same as 13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Pneumonia</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Malnutrition</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 days.</i> <i>several years</i> <i>years.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>March 19 69</i> to <i>May 19 69</i> , that (I) (we) lost saw the deceased alive on <i>April 30 19 69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Richard A. Yates</i> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/4/69</i>					
22d. PHYSICIAN'S NAME (Type) <i>R. A. YATES</i>				22e. ADDRESS <i>OLNEY, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5-7-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Congressional</i>				23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>			
24. FUNERAL DIRECTOR <i>Francis H. Barber</i>				ADDRESS <i>Laytonsville, Md.</i>		25a. REC'D BY REGISTRAR <i>MAY 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

07103

MINUTE OF DEATH

Pauline

Gov.

Director

Prochaville

Mr. Alexander Leverage

on

County National

2-1-03

Chief

Washington, D.C.

Francis B. Barber, Sec. of the

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07108

07104

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First Middle Last		2a. DATE KNOWN OF DEATH		ESTIMATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR	
James Ellsworth		Holland		May 7		1969		8:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR	
male	colored	Oct 6, 1934	34 YRS	MONTHS DAYS	HOURS MIN.	May 7		1969	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban		Laborer					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Mont. Rockville						King's Farm - Rt. 355	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
First Middle Last		First Middle Last						Pauline Holland - 201 N. Adams St. Rockville Md.	
UNKNOWN		Pauline Holland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pancreatitis. Acute Hemorrhagic									
3039 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute & Chronic Alcoholism - DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		John B. Bell		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		May 8, 1969	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/12/69		Lincoln Park		Rockville Mont. Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert L. Snowden		Rockville, Md.		MAY 13 1969		Charles George			

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF EXPERIMENTAL STATION

20170

STATE OF

INDIANA

RECEIVED

1917

20170

1917



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07109									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Jeffrey			Stephen			May		1969 Month 18 Day 1969	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Caucasian		August 22, 1960		8 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
California		USA				Montgomery		Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Naval Hospital			N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Montgomery			Rockville		604 Blossom Drive	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	
Bobby			F. Hollingsworth			Patricia		Marc-Aurele	
17. INFORMANT			18. ADDRESS			19. CITY OR TOWN		20. STATE	
CDR B. F. Hollingsworth, USCG,			604 Blossom			Drive, Rockville		Md	
19. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)									
21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from May 12, 19 69, to May 18, 19 69, that (I) (we) last saw the deceased alive on May 18, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bernard Jay Bortz, MD									
22c. DATE SIGNED May 19, 1969									
22d. PHYSICIAN'S NAME (Type)									
22e. ADDRESS Naval Hospital, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)									
23b. DATE 5-22-69									
23c. NAME OF CEMETERY OR CREMATORY Arlington National									
23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.									
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home									
25a. REC'D BY REGISTRAR MAY 23 1969									
25b. REGISTRAR'S SIGNATURE Charles Judge									



**FOR STATE  
HEALTH DEPT.**

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07110

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07106

1. DECEASED-NAME (Type or Print) <i>Mary May Hopkins</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>5</i> Day <i>26</i> Year <i>1969</i>			2b. HOUR <i>12:35 PM</i>		
3. SEX <i>Fe.</i>	4. RACE <i>Cauc</i>	5. DATE OF BIRTH <i>May 24 - 1975</i>	6. AGE (In years last birthday) <i>94</i> YRS.	7. UNDER 1 YEAR MONTHS <i>8</i> DAYS <i>15</i>	8. UNDER 24 HRS. HOURS <i>8</i> MIN. <i>15</i>	2c. DATE PRONOUNCED DEAD Month <i>5</i> Day <i>26</i> Year <i>1969</i>		
7a. BIRTHPLACE (State or foreign country) <i>Gen. Sch. Tenn.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>2700 Barker St. House - 100</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montg.</i>		13c. CITY OR TOWN <i>Sil. Sp.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2700 Barker St.</i>
14. FATHER'S NAME First <i>Edward</i> Middle <i>Rushworth</i> Last <i>Lynch</i>			15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Slick</i> Last <i>Slick</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Edward R. Hopkins</i>		18. ADDRESS <i>10900 Yorklake Dr. Bethesda, Md.</i>		
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4123 Gentle Coronary Insufficiency</i>								
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i>								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>5/26/1969</i>		
EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D.</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>May 29 - 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Walden Heights</i>		23d. LOCATION (City or town) (County) (State) <i>Bethesda Co. Tenn.</i>		
24. FUNERAL DIRECTOR <i>Arthur Walters</i>		ADDRESS <i>254 Carroll St. Wash. D.C.</i>		25a. REC'D BY REGISTRAR <i>MAY 29 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

01110

STATE  
INVESTIGATION

RECEIVED  
JAN 10 1954  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C.



JAN 10 1954

1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

071111

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07107

1. DECEASED-NAME (Type or print) <b>Douglas M</b>			First Middle Last			2a. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>1969</b>			2b. HOUR M <b>1</b>		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>Sept 25, 1903</b>			6. AGE (In years lost birthday) <b>65</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Travilah, Md</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Rockville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Stomach Valley Nurs H</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Rooper</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Rockville</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME <b>Thomas</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>Martha McGruder</b>			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <b>No.</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>578-09-3766</b>			17. INFORMANT <b>Catherine U. Hoyle-1011 Rockcrest Dr.,</b>			Address <b>Rockville, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/12/1968</b> , to <b>5/26/1969</b> , that (I) (we) lost the deceased alive on <b>5/24/1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Robert C. Macon</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>5/26/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>Robert C. Macon</b>						22e. ADDRESS <b>209 Viers Mill Rd, Rockville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>May 29, 1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Rockville, Montgomery, Maryland</b>		
24. FUNERAL DIRECTOR <b>Warner E. Humphrey, Inc.,</b>						ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>			25a. REC'D BY REGISTRAR <b>MAY 29 1969</b>		
									25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

05112

UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY

MAY 2 1963

100-10-10-10-10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

12 07112										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07108													
1. DECEASED-NAME (Type or print) First Middle Last Anna Jewel Huddleston										2a. DATE OF DEATH Month 5 Day 7 Year 69					2b. HOUR 1:55 PM								
3. SEX Female			4. RACE White			5. DATE OF BIRTH 2-19-38			6. AGE (In years lost birthday) 31 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) Tenn.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.														
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY												
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Prince Georges			13c. CITY OR TOWN handover			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2914 73rd Ave.											
14. FATHER'S NAME First Middle Last Robert Cumby			15. MOTHER'S MAIDEN NAME First Middle Last Mae Morgan			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 409-58-5711			17. INFORMANT Patients Hospital chart				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema, acute 2259 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Meningioma, tuberculum sellae DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
MEDICAL CERTIFICATION																							
19a. DATE OF OPERATION 23 May 69			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Neoplasm			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from 4/15, 1969, to 8 May, 1969, that (I) (we) last saw the deceased alive on 8 May, 1969, and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE Arthur Huddleston			DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 8 May 69																	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS 1015 Spring St. Silver Spring																				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE 5/9/69			23c. NAME OF CEMETERY OR CREMATORY Funeral Home			23d. LOCATION (City or Town) (County) (State) Cookeville Putnam Tenn														
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland						25a. REC'D BY REGISTRAR MAY 12 1969			25b. REGISTRAR'S SIGNATURE Charles Judge														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

07113		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07109	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
Graham				Hughes	May Month 23 Day 1969 or		837A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
Male		Caucasian		Feb. 3, 1949		20 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
New York		USA				Montgomery Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Naval Hospital		USMC			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
New York		V		Rochester		13e. STREET AND NUMBER	
						102 Mason Street	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
William		C.	Hughes		Fern		Tuckey
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
Yes 1968-69		088 44 4432		Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Septicemia with acute meningitis</u>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) <u>multiple fragment wounds</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. Mar 28 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) On duty			
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
at work		--		Republic of VietNam			
22a. I certify that (1) (this hospital attended the deceased from Apr. 27, 1969, to May 23, 1969, that (we) last saw the deceased alive on May 23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Donald K. Roeder, MD				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		23 May 1969	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
D.K. ROEDER, MD				Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		5-27-69				ROCHESTER NEW YORK	
24. FUNERAL DIRECTOR				25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. W. Chambers Co. 1400 Chapin Street, N.W. Washington, D.C.				MAY 27 1969		[Signature]	

05113

DEPARTMENT OF DEFENSE

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## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Charles Peter Hutterer</b>			2a. DATE OF DEATH Month <b>5</b> Day <b>30</b> Year <b>69</b>			2b. HOUR <b>6:25 AM</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>5-13-06</b>		6. AGE (In years last birthday) <b>63 YRS.</b>	
7a. BIRTHPLACE (State or foreign country) <b>Austria</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>ADMINISTRATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N.I.H.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md</b>		13b. COUNTY <b>montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>6316 OWEN PLACE</b>		14. FATHER'S NAME First <b>MANFRED</b> Middle <b>HUTTRER</b> Last <b>STRASSBERG</b>		15. MOTHER'S MAIDEN NAME First <b>ANNA</b> Middle <b>STRASSBERG</b> Last <b>STRASSBERG</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>098-12-6341</b>		17. INFORMANT <b>LUCY HUTTRER, WIDOW, SAME AS #13</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiac vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 years</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1962</b> , to <b>May 30, 1969</b> , that (I) (we) last saw the deceased alive on <b>May 29, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>BLAINE H. EIG</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5/30/1969</b>	
22d. PHYSICIAN'S NAME (Type) <b>BLAINE H. EIG</b>				22e. ADDRESS <b>9401 Deegan Creek Dr. Prince Georges Co. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>6-3-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Prince Georges Co. Md.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SON, INC.</b>				25a. REC'D BY REGISTRAR <b>JUN 5 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

04115

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

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07115 Ella

## CERTIFICATE OF DEATH

07111

1. DECEASED-NAME (Type or print) <b>Ella P. Ingram</b>			2a. DATE OF DEATH Month <b>5</b> Day <b>1</b> Year <b>69</b>			2b. HOUR <b>4:30 M</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>2-7-1889</b>		6. AGE (In years last birthday) <b>80</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>8601 Manchester Rd</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>8601 Manchester Rd</b>		14. FATHER'S NAME First Middle Last <b>Louis Palm</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Hilda Hildegarde</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs Mary Ellen Murtagh</b>		Address <b>8601 Manchester Rd Silver Spring</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <b>0</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>0</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>4-28</b> , 19 <b>67</b> , to <b>5-1</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4-7</b> , 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>M Snow MD</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5-2-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>M SNOW MD</b>				22e. ADDRESS <b>9013 FLOWER Silver Spring</b>			
23a. BURIAL (CREMATION) REMOVAL (Specify)		23b. DATE <b>5/3/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Bladensburg Rd. Md</b>	
24. FUNERAL DIRECTOR <b>W. C. Chambers Inc.</b>		ADDRESS <b>8558 2 Ave Silver Spring</b>		25a. REC'D BY REGISTRAR <b>MAY 6 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
07116									
07112									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
ESTHER			MAY INGRAM			MAY Month 4 Day Year 69			1p. M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE		WHITE		7-29-98		70 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
D.C.		AMERICAN				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
TAKOMA PARK			WASH. SAN & Hosp			HSEW			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MD			PR GEO		HYATTSVILLE		YES <input type="checkbox"/> NO <input type="checkbox"/>		7401 NEW HAMPSHIRE AVE
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Francis Homer Melick			Etoile Crandall						
16a. WAS DECEASED EVER IN U.S. ARMY FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
(If yes give war or dates of service)			577-01-0112D		PTs Chart				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiovascular accident</u>									30h.
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Arrhythmia fibrillation</u>									1mo.
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Hypertensive heart disease</u>									old
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					Street or R.F.O. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 1969, to <u>May 4</u> , 1969, that (I) (we) lost saw the deceased alive on <u>May 4</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
Ernest A. Sarao M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			5/4/69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
ERNEST A. SARAO M.D.					7006 NEW HAMPSHIRE Ave Takoma Park Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		May 7, 1969		Arlington National		Arlington		Virginia	
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Arthur Walters					MAY 7 1969		Charles Judge		

02116

STATE OF TEXAS

COUNTY OF DALLAS

NOTICE OF THE COURT OF THE COUNTY OF DALLAS, TEXAS, IN THE MATTER OF THE ESTATE OF JAMES EARL RAY, DECEASED.

THE COURT OF THE COUNTY OF DALLAS, TEXAS, IN THE MATTER OF THE ESTATE OF JAMES EARL RAY, DECEASED, has appointed the undersigned as executor of the estate of the said JAMES EARL RAY, deceased, and has authorized the undersigned to execute the same.

Witness my hand and the seal of the County of Dallas, Texas, this 1st day of May, 1968.

\_\_\_\_\_  
JAMES EARL RAY, JR.

NOTARY PUBLIC FOR THE COUNTY OF DALLAS, TEXAS

NOTARY PUBLIC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
BESSIE				SICKLE	INOFF	Month Day Year MAY 27 1969			3 <sup>30</sup> A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS.
FEMALE		HEBREW-WHITE		12/11/199		69 YRS.		MONTHS DAYS	HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED		9. COUNTY OF DEATH		Md.	
RUSSIA		U.S.A.		WIDOWED		MONTGOMERY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		HOLY CROSS		HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
M.D.		MONTG.		SIL SPRING		YES NO		1017-STROUT, S.T.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
HARRY					SICKLE	UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
NO			NONE		WM. SICKLE		1017-STROUT, ST. S.S. MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) RUPTURED DISSECTING ANEURYSM THORACIC AORTA								24 Hrs.	
DUE TO, OR AS A CONSEQUENCE OF									
(b) GENERALIZED ARTERIOSCLEROSIS									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES	
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(Enter nature of injury in Part 1 or Part 2, Item 18.)			
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. Month Day Year							
(If either, notify medical examiner)		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
While <input type="checkbox"/> Not while <input type="checkbox"/>		(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		Street or R.F.D. No.		City or Town		County State	
at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 26 May, 1969, to 27 May 1969, that (I) (we) last saw the deceased alive on 27 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
EUGENE P. LIBRE MD					27 May 1969				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
EUGENE P. LIBRE					10400 CONN. AVE. KENNINGTON MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
BURIAL		5/28/69		OHEV-SHELOM-CEM.		WASH.			D.C.
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
GOLDBERG FUNERAL HOME			901 ST. N.W.			MAY 29 1969		J. Charles Jager	

0515



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07118

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

07114

1. DECEASED-NAME (Type or print) First Middle Last <b>Dora Isard</b>			2a. DATE OF DEATH Month Day Year <b>May 19 1969</b>		2b. HOUR <b>11 AM</b>
3. SEX <b>Female</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH <b>Feb. 21, 1890</b>		6. AGE (In years last birthday) <b>79</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carriage Hill ECF</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Washington</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>1425 Manchester Lane, N. W.</b>
14. FATHER'S NAME First Middle Last <b>Harry Fulmer</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Jennie ? ?</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>NO</b> (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>087-16-6711-B</b>		17. INFORMANT Address <b>Mrs. Hilda Bloom, 1119 Quebec St. Sil. Spr. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction (probable)</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic heart disease</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF -- (c) <b>With congestive heart failure</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21f. LOCATION Street or R.F.D. No. City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>10 NOV 1968</b> , to <b>19 MAY 1969</b> , that (I) (we) saw the deceased alive on <b>17 MAY 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Donald B. Doty</b> DEGREE				22c. DATE SIGNED <b>19 May 69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. Donald B. Doty</b>				22e. ADDRESS <b>1909 Hanover Street, Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 21, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>	
23d. LOCATION (City or Town) (County) (State) <b>Falls Church Va.</b>		23e. LOCATION (City or Town) (County) (State) <b>Falls Church Va.</b>			
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home 4217 9th St., N.W.</b>				25a. REC'D BY REGISTRAR <b>MAY 23 1969</b>	
				25b. REGISTRAR'S SIGNATURE <b>O'Connell, Indel</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

071119 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 14 & 15 Film 413 6/13/69 kk

CERTIFICATE OF DEATH

07115

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Emma Porter Jackson						5	Month	25	Day	12 <sup>43</sup> A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		white		2-13-78		91 YRS.		MONTHS	DAYS	HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Montgomery		Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park			SANTARIUM + Hospital			House wife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			PG		Chillum			906 Somerset Pl.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Adam			thommas		thompson	Ellen			19		Spear
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			Unknown			Wash. San + Hospt. Med. records			Takoma Park, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Carcinoma of the colon</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Known 2 years</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
<u>Arteriosclerotic Heart Disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County	State
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <u>May 23, 1969</u> , to <u>May 25, 1969</u> , that (I) (we) last saw the deceased alive on <u>May 24, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS.		22c. DATE SIGNED	
Aaron H. Traum M.D.								<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		May 25, 1969	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
AARON H. TRAUM						5237 Georgia Ave Silver Spring Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		May 28, 1969		Fort Lincoln Cemetery		Colmar Manor Rd		Pr		Md	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Takoma Funeral Home						DATE MAY 27 1969		X Charles Judas			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A151(4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last John August Johansson			2a. DATE OF DEATH Month Day Year 6 14 69			2b. HOUR 7 <sup>00</sup> A-M			
3. SEX M		4. RACE Amer. - White		5. DATE OF BIRTH 9-15-94		6. AGE (In years lost birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Sweden		7b. CITIZEN OF WHAT COUNTRY? Amer. U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 708 Hankin St.	
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2050 Acute Myelomonocytic Leukemia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5/3, 1969, to 5/17, 1969, that (I) (we) last saw the deceased alive on 5/16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Israel Spector MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/17/69			
22d. PHYSICIAN'S NAME (Type) Israel Spector				22e. ADDRESS 911 Silver Spring Ave. Silver Spg Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5/24/69		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges County Md.			
24. FUNERAL DIRECTOR The H. Hines Co				ADDRESS 2885 14th St NW Washington DC		25a. REC'D BY REGISTRAR DATE MAY 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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At the Department of Health and Human Services

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Mr. [illegible]

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U.S. Department of Health and Human Services

MAY 1 1983



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07117	
07121										CERTIFICATE OF DEATH	
1. DECEASED-NAME (Type or print) First Middle Last Marjorie Evelyn JONES						2a. DATE OF DEATH Month Day Year May 28 1969			2b. HOUR 1:15 M		
3. SEX Female		4. RACE Cauc		5. DATE OF BIRTH 10 October 1922		6. AGE (In years last birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Nebraska		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital, Beth Md		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Fairfax		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3122 Wynford Dr.			
14. FATHER'S NAME First Middle Last Kenneth J Hicks				15. MOTHER'S MAIDEN NAME First Middle Last Iona Schaffer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 506-18-8441		17. INFORMANT Address Frank R. Jones 3122 Wynford Dr. Fairfax Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of Breast</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 174X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <del>Dr.</del> (this hospital) attended the deceased from <u>7 May</u> , 19 <u>69</u> , to <u>28 May</u> , 19 <u>69</u> , that <del>Dr.</del> (we) last saw the deceased alive on <u>28 May</u> , 19 <u>69</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(Dr.)</del> (we) (did) <del>(not)</del> view the body after death.											
22b. SIGNATURE <i>Antony Graybiel</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 28 May 1969					
22d. PHYSICIAN'S NAME (Type) A. L. GRAYBIEL, LCDR MC USN				22e. ADDRESS Naval Hospital, Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 31, 1969		23c. NAME OF CEMETERY OR CREMATORY Memor National Memorial Park Falls Church Fairfax Va.		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR COVINGTON MARTIN				ADDRESS FURNAL HOME, 6161 LEESBURG PIKE, VIRGINIA		25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>			

07121

STATE OF TEXAS

County of \_\_\_\_\_

Know all men by these presents, \_\_\_\_\_ of the County of \_\_\_\_\_ State of Texas, for and in consideration of the sum of \_\_\_\_\_ Dollars, to \_\_\_\_\_ of the County of \_\_\_\_\_ State of Texas, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said \_\_\_\_\_ of the County of \_\_\_\_\_ State of Texas, all that certain \_\_\_\_\_

TO HAVE AND TO HOLD unto the said \_\_\_\_\_ heirs, assigns and assigns forever.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, this \_\_\_\_\_ day of \_\_\_\_\_ A.D. 19\_\_\_\_.

\_\_\_\_\_  
Notary Public in and for the State of Texas

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07122

07118

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN <input type="checkbox"/> Month Day Year		2b. HOUR
Joseph		William	Jozefczyk		2a. DATE KNOWN <input checked="" type="checkbox"/> May 7 1969		7:10 AM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	12-06-34	30 YRS.			5 Day 7 Year 1969	7:51 AM
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Pa.	U.S.A.			Montgomery			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Rockville			Asst. manager GEICO				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Md.	Mont.	Bethesda		10607 Kenilworth Ave, Apt			
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last					
Joseph Jozefczyk		Clara Bartman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS		
yes		1961	Unknown		Wife Victoria Jozefczyk Same as Item 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries Severe							Sudden
8120 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Trauma from auto accident							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		7:08 AM 5/7 19 69		Car he was driving was struck by truck			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
	Highway		Montrose & Rockville Pike, Bethesda, Mont. Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)		JOHN G. BALL		5/7/69			
		ADDRESS (Street, city, town, or county)		Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial	5-10-69	Monongahela Cemetery		Monongahela, Penna.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ROBERT A. PUMPHREY, Bethesda, Maryland				MAY 12 1969		Charles Judge	

9258

STAFF: 24  
POLICE: 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07123		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07119	
Item 13 Film 413 6/3/69 kk					
1. DECEASED-NAME (Type or print) First Middle Last Gertrude Keren			2a. DATE OF DEATH Month 5 Day 25 Year 69		2b. HOUR 1:54 A.M.
3. SEX female	4. RACE white	5. DATE OF BIRTH Nov. 27, 1915		6. AGE (In years lost, months, days) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Chelsea, Mass.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda Home of Greater Washington	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN (If outside CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Rockville	13d. STREET AND NUMBER 708 Sligo Ave. 6121 Montrose Rd.		
14. FATHER'S NAME First Middle Last Kussel Keren			15. MOTHER'S MAIDEN NAME First Middle Last Mary Baicobitz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.	17. INFORMANT Heinz J. Lorge, M.D., 6121 Montrose Rd, Rockville		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X Dilatation of heart due to overstrain DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emphysema (c) Asthma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 15 years 25 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Diabetes mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from April 1, 1948, to May 25, 1969, that (I) (we) last saw the deceased alive on May 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Heinz J. Lorge, M.D.		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/25/69	
22d. PHYSICIAN'S NAME (Type) Heinz J. Lorge		22e. ADDRESS 6121 Montrose Road, Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/26/69		23c. NAME OF CEMETERY OR CREMATORY ELES AVETERAD. CEM	
23d. LOCATION (City or Town) (County) (State) WASH. D.C.		24. FUNERAL DIRECTOR Bernard Dangersky & Son		25a. REC'D BY REGISTRAR DATE MAY 28 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge					

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07124		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07120	
1. DECEASED-NAME (Type or print)				First Middle Lost		20. DATE OF DEATH	
William				Kitt		May 16, 1969	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost-birthday)	
Male		White		9/3/01		67 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Virginia		U.S.A.				Montgomery Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney		Montgomery General		Farmer		Farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
STATE Md.		13b. COUNTY Montgomery		Gaithersburg YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2 N. Summit Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		16b. SOCIAL SECURITY NO.	
First Middle Lost		First Middle Lost		NO		229 16 2031	
William XXXXXX Kitt		Minnie Gullion					
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. ADDRESS		20. DATE SIGNED	
Mr. Gullion		2 N. Summit Ave. Gaithersburg Md.					
21. MEDICAL CERTIFICATION		22. I certify that (I) (this hospital) attended the deceased from April 19, 1969, to May 16, 1969, that (I) (we) last saw the deceased alive on May 13, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		23. NAME OF CEMETERY OR CREMATORY		24. FUNERAL DIRECTOR	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		23a. NAME OF CEMETERY OR CREMATORY		24a. FUNERAL DIRECTOR	
				Kimberling Luth. Cem.		Tyson Wheeler F. H.	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		25a. REC'D BY REGISTRAR	
						MAY 19 1969	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		25b. REGISTRAR'S SIGNATURE	
						Charles Judge	

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1982

1983

1984

1985

1986

1987

1988

4379

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07125		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07121	
Item 13 Film 413 6/6/69 kk					
1. DECEASED-NAME (Type or print)			2a. DATE OF DEATH		2b. HOUR
First Middle Last <i>Jacob Kligman</i>			Month Day Year <i>5 28 1969</i>		Min <i>7:15 P</i>
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
<i>male</i>	<i>white</i>	<i>Nov 12, 1893</i>		<i>75</i> YRS.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
<i>Russia</i>	<i>USA</i>		<i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
<i>Rockville</i>	<i>Hebrew Home - Aged</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
<i>D.C.</i>	<i>Washington</i>		<i>7512 Eastern Ave. N.W.</i>		
14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last				
<i>Yeskel Kligman</i>	<i>Toba -</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address			
		<i>Charles J. Kligman, Son, Beth, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis, cerebral</i> <i>4379</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis, generalized</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i> <i>10 yrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Chronic pyelonephritis</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>March 16</i> , 19 <i>66</i> , to <i>May 28</i> , 19 <i>69</i> , that (I) (we) lost the deceased alive on <i>May 28</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Heinz J. Lorge</i>		22c. DATE SIGNED <i>May 28, 69</i>		22d. ADDRESS <i>Hebrew Home of Greater Washington</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	25a. REC'D BY REGISTRAR	
<i>Burial</i>	<i>5/30/69</i>	<i>Ohev Sholom Talmud Torah - Wash., D.C.</i>		<i>3 1969</i>	
24. FUNERAL DIRECTOR ADDRESS			25b. REGISTRAR'S SIGNATURE		
<i>Bernard Danzansky &amp; Sons-3501 14th St. Wash., D.C. 20010</i>			<i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07126

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07122

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Pete Joseph KOZAR</b>			2a. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1969</b>		2b. HOUR <b>953A</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>July 22, 1921</b>		6. AGE (In years last birthday) <b>47</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>U.S. Navy</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Florida</b>	13b. COUNTY <b>DUVAL</b>	13c. CITY OR TOWN <b>Jacksonville</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>4348 Woodmere Street</b>	
14. FATHER'S NAME First <b>Nicholas</b> Middle <b>Kozar</b> Last <b>Luzeki</b>		15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Luzeki</b> Last <b>Luzeki</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>298 01 3783</b>		17. INFORMANT <b>Jacksonville</b> Address <b>Florida</b> <b>Mrs. L. Kozar, 4348 Woodmere St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis with</b> <b>arteriosclerotic heart disease and recent septal</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF <b>myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 23</b> , 19 <b>69</b> , to <b>May 18</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 18</b> , 19 <b>69</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Mitchell Mills</b> DEGREE ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS. <b>May 19, 1969</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>Mitchell Mills, M. D.</b>				22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5-23-69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington</b>		23d. LOCATION (City or Town) (County) (State) <b>Va.</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers Co.</b> ADDRESS <b>1400 Chapin St., N. W. Washington, D. C.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 23 1969</b>	
				25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>	

25150

44

*Journal of Management Education*

1997

continued

1972-73

D. M. Clark, Editor

1100 Ontario St., N. W. Washington 25, D. C.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07123

07127

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>First Ralph Middle H. Last KRAPP</b>			2a. DATE OF DEATH Month <b>5</b> Day <b>4</b> Year <b>1969</b>			2b. HOUR <b>7:45</b> M			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>5-14-1889</b>		6. AGE (In years (In years birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Bethesda Silver Spring N.H.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Dist. of Col.</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4545 Conn. Ave. N.W.</b>	
14. FATHER'S NAME <b>First George Middle Krapp Last</b>			15. MOTHER'S MAIDEN NAME <b>First Jennie Middle Isaacs Last</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>060-0542867-A</b>		17. INFORMANT Address <b>Mrs. Anna Krapp, Widow, same as item #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>4339</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/23</b> , 19 <b>67</b> , to <b>5/4</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>5/3</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>S.W. Nealon Jr. M.D.</b> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5/6/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>S. W. Nealon Jr.</b>				22e. ADDRESS <b>915 19th St. N.W., Wash., D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-7-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) Md. <b>Silver Spring, Montgomery Co.</b>			
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SON, 11 ADDRESS</b>				25a. REC'D BY REGISTRAR <b>MAY 8 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Yague</b>			

87137

RECORD OF DATA

Name	Occupation	Date	Age	Sex
Mr. John	Chief Clerk	1-1-1909	29	M
Miss Clara	Bookkeeper	1-1-1909	29	F
Miss Mary	Teacher	1-1-1909	29	F
George	Carpenter	1-1-1909	29	M
No	000-0-00000-1	1-1-1909	29	M

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07128

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07124

1. DECEASED-NAME (Type or Print)		First ANNA		Middle V.		Last KREISINGER		2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 5-25 1969 7 <sup>PM</sup>		2b. HOUR M	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH VERMONT		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year May 25 1969 7 <sup>PM</sup>	
7a. BIRTHPLACE (State or foreign country) VERMONT		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4712 S. Chelsea La.			
14. FATHER'S NAME First Middle Last EUGENE VAN ORMAN		15. MOTHER'S MAIDEN NAME First Middle Last NORA GOODNOUGH									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) -		17. INFORMANT ADDRESS ROBERT KREISINGER, HUSBAND, SAME AS ITEM #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis, old and recent</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Advanced Coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cerebral infarct, old left cerebral</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED May 26, 1969							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 5-28-1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges Co., Md.			
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC. 5130 WISC. AVE., N. W. WASH., D. C. 20016				25a. REC'D BY REGISTRAR DATE MAY 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

07132

UNITED STATES

ARMY

JOHN H. HANCOCK

RECEIVED

1917

RECEIVED

ARMY

RECEIVED

1917

NO

RECEIVED

RECEIVED

RECEIVED

John D. Ball

Central Hill Cemetery

RECEIVED

RECEIVED

RECEIVED

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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## MARYLAND DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07125

1. DECEASED-NAME (Type or Print) <i>Thomas Burnett Lamb</i>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 5 30 1969 <i>9:35</i> M		
3. SEX <i>MA</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>10/6/1910</i>	6. AGE (In years lost birthday) <i>58</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Wheaton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>2908 Parker Ave.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Steel-</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Wheaton</i>	
14. FATHER'S NAME First <i>Patrick Lamb</i> Middle <i></i> Last <i></i>		15. MOTHER'S MAIDEN NAME First <i>Elizabeth Burnett</i> Middle <i></i> Last <i></i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i></i>	
16b. SOCIAL SECURITY NO. <i></i>		17. INFORMANT ADDRESS <i>Mrs Dorothy Lamb, 2908 Park Ave, Wheaton Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Lacerations Multiple</i> <i>955X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>gun shot wound through palate</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <i>5/30 1969</i> HOUR AM <i>9:35</i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Shot Self with Rifle in mouth</i>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>2908 Parker Ave</i> City or Town <i>Wheaton</i> County <i>Montgomery</i> State <i>Ma.</i>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John G. Bell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>May 31, 1969</i>	
EXAMINER'S NAME (Type) <i>John G. Bell</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <i></i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>6/3 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>	
24. FUNERAL DIRECTOR <i>W.R. Huntmann &amp; Son</i>		ADDRESS <i>5732 Georgia Ave NW</i>		25b. REGISTRAR'S SIGNATURE <i>Phonola Judge</i>	

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STATE NO.  
10000000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15  
30M REV. 1-68

07130		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07126				
1. DECEASED-NAME (Type or print) First Middle Last Agnes Ashford LANE						2a. DATE OF DEATH Month Day Year May 2 1969		2b. HOUR P M 7:15 P		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH August 2, 1904		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 19 Wagner Street		
14. FATHER'S NAME First Middle Last Snowden Ashford		15. MOTHER'S MAIDEN NAME First Middle Last Annette Crichton								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 426-60-8495		17. INFORMANT Address Va. Beach, Va. James A. Metcalfe, 4001 Edinburgh Drive						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BREAST WITH MULTIPLE METASTASIS</u> 174 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from <u>7 Apr</u> , 19 <u>69</u> , to <u>2 May</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>2 MAY</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE A Graybiel MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4 MAY 1969
22d. PHYSICIAN'S NAME (Type) LCDR A.L. GRAYBIEL, MC, USN				22e. ADDRESS Naval Hospital, Bethesda, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-5-69		23c. NAME OF CEMETERY OR CREMATORY St. Anne's Parish Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis Anne Arundel Maryland				
24. FUNERAL DIRECTOR John M. Taylor, 147-149 Gloucester, Annapolis				ADDRESS Maryland		25a. RECEIVED BY REGISTRAR MAY 6 1969		25b. REGISTRAR'S SIGNATURE		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Joseph Francis Lavin						May 11, 1969			10 PM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
male	white		May 11, 1969			5-11-69		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland			United States					Montgomery Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring			Holy Cross Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Montgomery			Rockville		531 Brent Road	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
James Anthony Lavin						Margaret Catherine Tyrell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
						Mother			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 777X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May 11, 1969, to June 1, 1969, that (I) (we) last saw the deceased alive on June 1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Marvin Tabb</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/11/69 10 PM	
22d. PHYSICIAN'S NAME (Type) Marvin Tabb						22e. ADDRESS 2401 Blue Ridge Ave Wheaton Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			5/19/69			Mt. Olivet			WASH. D.C.
24. FUNERAL DIRECTOR JMS. T. RYAN, Inc. John J.						ADDRESS 317 Pk. Ave., S.E.		25a. REC'D BY REGISTRAR MAY 15 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge									

1971

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07132

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07128

1. DECEASED-NAME (Type or print) <i>Herbert Oliver Lee, Sr.</i>			2a. DATE OF DEATH Month <i>5</i> Day <i>7</i> Year <i>69</i>			2b. HOUR <i>8:25</i> <i>A</i> <i>M</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>7-11-10</i>		6. AGE (In years last birthday) <i>58</i> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.				
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Jan. &amp; Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Butcher</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>9108 2nd Ave</i>	
14. FATHER'S NAME First <i>Benjamin</i> Middle <i>F.</i> Last <i>Lee</i>			15. MOTHER'S MAIDEN NAME First <i>Eugenia</i> Middle <i>Chinn</i> Last <i>Chinn</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <i>No</i> (If yes give war or dates of service) <i>-</i>			16b. SOCIAL SECURITY NO. <i>577-10-7870</i>		17. INFORMANT <i>Hospital Records</i> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Ischemia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Extensive Coronary Sclerosis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>		
								<i>3 days</i>		
								<i>Years</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>① Gangrene left leg ② Generalized Severe Obstructive Atherosclerosis ③ Cerebral Sclerosis</i>										
19a. DATE OF OPERATION <i>4/23/69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Atherosclerosis + Obstruction Femoral</i>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Auto</i>						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>4/22</i> , 19 <i>69</i> , to <i>5/2</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5/6</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Marvin L. Kolkin</i>				DEGREE <i>MD.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/2/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>MARVIN L. KOLKIN</i>				22e. ADDRESS <i>1015 Spring Street, S.E., Md</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>5/10/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Md.</i>				
24. FUNERAL DIRECTOR <i>Nalley's Funeral Home Inc.</i>				ADDRESS <i>Mt. Rainier, Maryland</i>		25a. REC'D BY REGISTRAR <i>MAY 12 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*



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VR A15  
45M - 11-69

07133		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07129	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last Martin A. Leibold			2a. DATE OF DEATH Month Day Year May 29 1969			2b. HOUR 3:37 M	
3. SEX male		4. RACE white		5. DATE OF BIRTH 7/25/92		6. AGE (In years last birthday) 76 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Govt		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Mont.		13c. CITY OR TOWN Cherry Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Paul Leibold		15. MOTHER'S MAIDEN NAME First Middle Last Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. 213-48-1863		17. INFORMANT Ellen Leibold / 1629 W. Myrtle Ave / Bethesda, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 2 hr							
4109 DUE TO, OR AS A CONSEQUENCE OF <u>Acute Coronary Thrombosis</u> 2 days							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Coronary Heart Disease</u> 2 years							
(c) <u>Chronic Coronary Heart Disease</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5/28 1969, to 5/29 1969, that (I) (we) last saw the deceased alive on 5/28 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Frank Y. Jagers Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/29/69 Cherry Chase Md.	
22d. PHYSICIAN'S NAME (Type) FRANK Y. JAGGERS JR.				22e. ADDRESS 5707 WISCONSIN AVE			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-2-69		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.				25a. REC'D BY REGISTRAR DATE JUN 5 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

07100

UNITED STATES OF AMERICA

1915

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07134

CERTIFICATE OF DEATH

07130

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3718-Williams Lane</u>				d. STREET ADDRESS <u>3718 Williams Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>HENRIETA</u> Middle <u>M.</u> Last <u>LEONARD</u>				4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1969</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct-30 1883</u>	
9. AGE (In years, last birthday) <u>85 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>James town New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>HECTOR MORRISON</u>			
14. MOTHER'S MAIDEN NAME <u>ELLEN FITZPATRICK</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>219-54-9633</u>				17. INFORMANT <u>SON</u> Address <u>3718 Williams Lane</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 398X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Rheumatic Heart Disease</u> (c) <u>20 years</u> DUE TO (e), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>May 24</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 24</u> , 19 <u>69</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Irene G. Tamagna</u>				22b. DATE SIGNED <u>May 24-1969</u>		22c. PHYSICIAN'S NAME (Type) <u>IRENE G. TAMAGNA M.D.</u>	
22d. ADDRESS <u>7101 CONNECTICUT AVE Chevy Chase</u>				22e. ADDRESS <u>  </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/28/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEM.</u>		23d. LOCATION (City, town or county) (State) <u>SILVER SPRING MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HANCOX FUNERAL HOME WASH D.C.</u>				25a. REC'D BY REGISTRAR <u>MAY 29 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

VR A15 (4)  
15M 7/61

ALABAMA STATE DEPARTMENT

STATE DEPARTMENT OF REVENUE

07100

OFFICE OF STATE

07100



THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON HAS BEEN RECEIVED IN THE OFFICE OF THE STATE DEPARTMENT OF REVENUE AND IS NOW IN THE POSSESSION OF THE SAME.

OFFICE OF STATE

07100

07100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07135		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07131	
Item 13 Film 412 5/9/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) First Middle Last DAVID K- LEONHARD		2a. DATE OF DEATH Month Day Year 5 1 1969		2b. HOUR 12:30 A.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH Apr 10, 1895	
6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) ILLINOIS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH MONTGOMERY		Md.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Spec. Police	
12b. KIND OF BUSINESS OR INDUSTRY Govt.		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN MONTGOMERY WHEATON	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 901 Arcola Avenue			
14. FATHER'S NAME First Middle Last William H. Leonhard		15. MOTHER'S MAIDEN NAME First Middle Last Marie Klein			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO. 1917-19 1921-23		17. INFORMANT Rose Leonhard, Wife Address 6402 B Street, S. E., Maryland Park, Md. 20027	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASHD</u> 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/20, 1969, to 4/30, 1969, that (I) (we) last saw the deceased alive on 4/30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Myron L. Lenkin		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/16/69	
22d. PHYSICIAN'S NAME (Type) MYRON L. LENKIN		22e. ADDRESS 2309 SHOREFIELD RD. SILVER SPRING MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/5/69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		25a. REC'D BY REGISTRAR MAY 5 1969		25b. REGISTRAR'S SIGNATURE William J. ...	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Rd., S.E., Suitland, Md., 20023					

07135

THE MOUNT OF MOUNTAIN

There is a small stream  
which runs through the  
valley. The water is  
very clear and the  
rocks are very smooth.  
The mountains are very  
high and the sky is  
very blue.

1880

The mountains are very  
high and the sky is  
very blue. The water is  
very clear and the  
rocks are very smooth.  
There is a small stream  
which runs through the  
valley.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm and city health records. Pages 1, 2, and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 413 MARYLAND STATE DEPARTMENT OF HEALTH  
6-9-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**07136 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07132

1. DECEASED-NAME (Type or Print)			First Tracy Middle Scott Last Lewis			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b. HOUR		
3. SEX M			4. RACE W			5. DATE OF BIRTH 10-1-68			6. AGE (In years last birthday)		
						IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) W. Va.			7b. CITIZEN OF WHAT COUNTRY? US			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Takoma Park, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington, San & Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Montgomery			13c. CITY OR TOWN Takoma Park			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Jerry Middle Lewis Last			15. MOTHER'S MAIDEN NAME First Charlotte Middle Ellen Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to airway obstruction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>with food (graham cracker)</u> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 11:20AM 5-12 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased infant aspirated particles of food					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f. LOCATION Street or R.F.D. No. City or Town County State Takoma Park Montgomery Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			Belden R. Reap, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED May 12, 1969		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE May 15, 1969			23c. NAME OF CEMETERY OR CREMATORY Perry Alta Cemetery			23d. LOCATION (City or Town) (County) (State) Perry Alta West Va.		
24. FUNERAL DIRECTOR J. Walter			ADDRESS 254 Carroll St NW Wash DC			25a. REC'D BY REGISTRAR MAY 14 1969			25b. REGISTRAR'S SIGNATURE J. Walter		

07136

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 175 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>ARCH</b> <sup>First</sup> <b>B.</b> <sup>Middle</sup> <b>LYLE</b> <sup>Last</sup>					2a. DATE OF DEATH <b>5</b> Month <b>6</b> Day <b>69</b> Year		2b. HOUR <b>10:35</b> M			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>6/10/196</b>		6. AGE (In years lost birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.				
10. CITY OR TOWN OF DEATH <b>SILVER SPRING, MD.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOLY CROSS HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>107E MELBOURNE AVE.</b>	
14. FATHER'S NAME First <b>WINIFREE</b> Middle <b>COONROCK</b> Last <b>LYLE</b>			15. MOTHER'S MAIDEN NAME First <b>UNKNOWN</b> Middle <b>UNKNOWN</b> Last <b>UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>2/13/15 - 2/12/22</b>			16b. SOCIAL SECURITY NO. <b>577-16-1598</b>		17. INFORMANT Address <b>Silver Spring, Md.</b> <b>MARY M. LYLE - 107E. MELBOURNE AVE., MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Possible Pulmonary Embolism</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Lung, Left</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 yrs</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>67</b> , to <b>5/6</b> , 19 <b>67</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>5/6</b> , 19 <b>67</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.										
22b. SIGNATURE <b>G. Leonard Gold</b> DEGREE <b>MD</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5/6/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>G. Leonard Gold</b>					22e. ADDRESS <b>9801 Georgia Ave., Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 9, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) <b>Suitland,</b> (County) <b>Maryland</b> (State)				
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc., 8434 Georgia Avenue</b>					25a. REC'D BY REGISTRAR <b>MAY 8 1969</b>		25b. REGISTRAR'S SIGNATURE <b>G. Leonard Gold</b>			

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07138					07134				
1. DECEASED-NAME (Type or print) <i>CATHERINE B. MAGEE</i>					2a. DATE OF DEATH Month <i>May</i> Day <i>3</i> Year <i>1969</i>			2b. HOUR <i>1:50 A</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>9/9/04</i>		6. AGE (In years last birthday) <i>64</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>TEXAS</i>		7b. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			
10. CITY OR TOWN OF DEATH <i>BETHESDA</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>RESEARCHER - RETIRED</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. GOV'T.</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>DC</i>		13b. COUNTY <i>WASHINGTON</i>		13c. CITY OR TOWN <i>DC</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>6031 Utah Ave. N.W.</i>	
14. FATHER'S NAME First <i>E.</i> Middle <i>B.</i> Last <i>BYNUM</i>		15. MOTHER'S MAIDEN NAME First <i>KITTY</i> Middle <i>CHAPFIELD</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>426-07-9206</i>		17. INFORMANT <i>O.H. BYNUM, BROTHER, DALLAS, TEXAS</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Cortical Atrophy</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>3 days</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<i>Fibrous Myocardial Septum</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>July 19, 1969</i> to <i>May 3, 1969</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>May 2, 1969</i> , and that in my <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <i>(did)</i> <del>(did not)</del> view the body after death.									
22b. SIGNATURE <i>Michel M. Healy MD</i>		22c. DATE SIGNED <i>5/3/69</i>		22d. PHYSICIAN'S NAME (Type) <i>Michel M. Healy, MD</i>					
22e. ADDRESS <i>5411 Cedar Lane, Bethesda, Maryland</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>5-5-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Prince Georges Co. MD</i>			
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SON, INC.</i>		25a. REC'D BY REGISTRAR <i>MAY 8 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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John M. Kelly, Jr.

John M. Kelly, Jr.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07139

CERTIFICATE OF DEATH

07135

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P			
Harry Milton Magruder						May 14 1969			3:09 PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		Negro		22 August 1894			74 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.					
Washington, D.C.		USA										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			The Clinical Center, NIH									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
District of Columbia			13b. COUNTY			Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		511 L Street, N.W.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
James					Magruder	Eva					Hughes	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT The Medical Record Address						
			578-14-4114			The Clinical Center, NIH, Bethesda, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram negative sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Urinary tract infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Acute leukemia</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7 May, 1969, to 14 May, 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 14 May, 1969, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.												
22b. SIGNATURE Robert E. Gallagher, M.D.						22c. DATE SIGNED 14 May 1969		22d. PHYSICIAN'S NAME (Type) Robert E. Gallagher, M.D.				
22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland												
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)						
Burial		5-19-1969		Harmony Memorial Park		Landover, Maryland						
24. FUNERAL DIRECTOR Wash. D. C. ADDRESS MAIVAN & SCHEY, INC. 424 R St., N. W.						25a. REC'D BY REGISTRAR DATE MAY 19 1969		25b. REGISTRAR'S SIGNATURE P. Charles Gudge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared thru Dr. John G. Ball, Dept. Med. Exam., Montg. Co., Md.

1 and 2  
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
DANIEL			B. MAHER			MAY 23, 1969			10:30 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years)		IF UNDER 1 YEAR	
Male		Caucasian		Jan. 20, 1906		65 (thday)		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
N.J.		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			5405 Lambeth Road			Attorney			Law
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.			Montg.		Bethesda	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5405 Lambeth Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Edward F. Maher			Martha E. Cunningham						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No					Helen W Maher, Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>									
4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Arteriosclerosis HD</u>									10 yrs +
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>									15 yrs +
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus 10 yrs +</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/21/69</u> , to <u>5/23/69</u> , that (I) (we) last saw the deceased alive on <u>5/21/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
Thomas F. Keliher									5/23/69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
					3800 Reservoir Rd. Wash. D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		5/27/69		PARKLAWN Cem.		ROCKVILLE, MD.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
JOS. GAWLERISONS, 5130 WISCONSIN AVE. WASHINGTON, D.C.					MAY 28 1969		Charles J. Judd		

07140

STATE OF CALIFORNIA

MARRIAGE

AND

DIVORCE

Jan. 20, 1906

California

Name

Montgomery

X

U.S.A.

N.B.

Law

Attorney

105 Lombard Road

Address

2105 Market Street

X

Between

Robert

and

Quinn

Robert

Robert

and

Edward

Robert M. Robert, same as 190

and

Thomas F. Robert

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last <b>EVALIN NMN MALONY</b>					2a. DATE OF DEATH Month <b>5</b> Day <b>31</b> Year <b>69</b>			2b. HOUR <b>7:50A</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>11-29-20</b>		6. AGE (In years, lost birthday) <b>48</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.			
10. CITY OR TOWN OF DEATH <b>OLNEY</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MONTGOMERY GENERAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>PSYCHIATRIC SUPT.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>GAITHERSBURG</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RFD #2, Box 202</b>	
14. FATHER'S NAME First Middle Last <b>HAROLD MITCHELL</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY HOLLIDAY</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <b>118-18-9425</b>		17. INFORMANT <b>Mary H. Mitchell</b>		Address <b>Same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1830</b> IMMEDIATE CAUSE (a) <b>Cerebrovascular Emboli</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary Emboli</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ovarian Cancer</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Days</b> <b>Months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>none</b>									
19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Apr 10</b> , 19 <b>69</b> , to <b>May 31</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>May 31</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>STEVEN CONWAY MD</b>				22c. DATE SIGNED <b>5/31/69</b>		22d. PHYSICIANS NAME (Type) <b>STEVEN CONWAY MD</b>			
22e. ADDRESS <b>570 NO FREDERICK</b>				22f. ADDRESS <b>GAITHERSBURG MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>June 2 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Donation to George Wash. Medical school</b>		23d. LOCATION (City or Town) (County) (State) <b>Wash. D.C.</b>			
24. FUNERAL DIRECTOR <b>Francis H. Barber Funeral Home Laytonsville</b>				25a. REC'D BY REGISTRAR <b>JUN 5 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Richard Judge</b>			

June 2 1909 Donation to George Washington Medical School Wash. D.C.

Francis H. Barber Funeral Home Lexington, Va. 5 1909



**FOR STATE  
HEALTH DEPT.**

07142

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

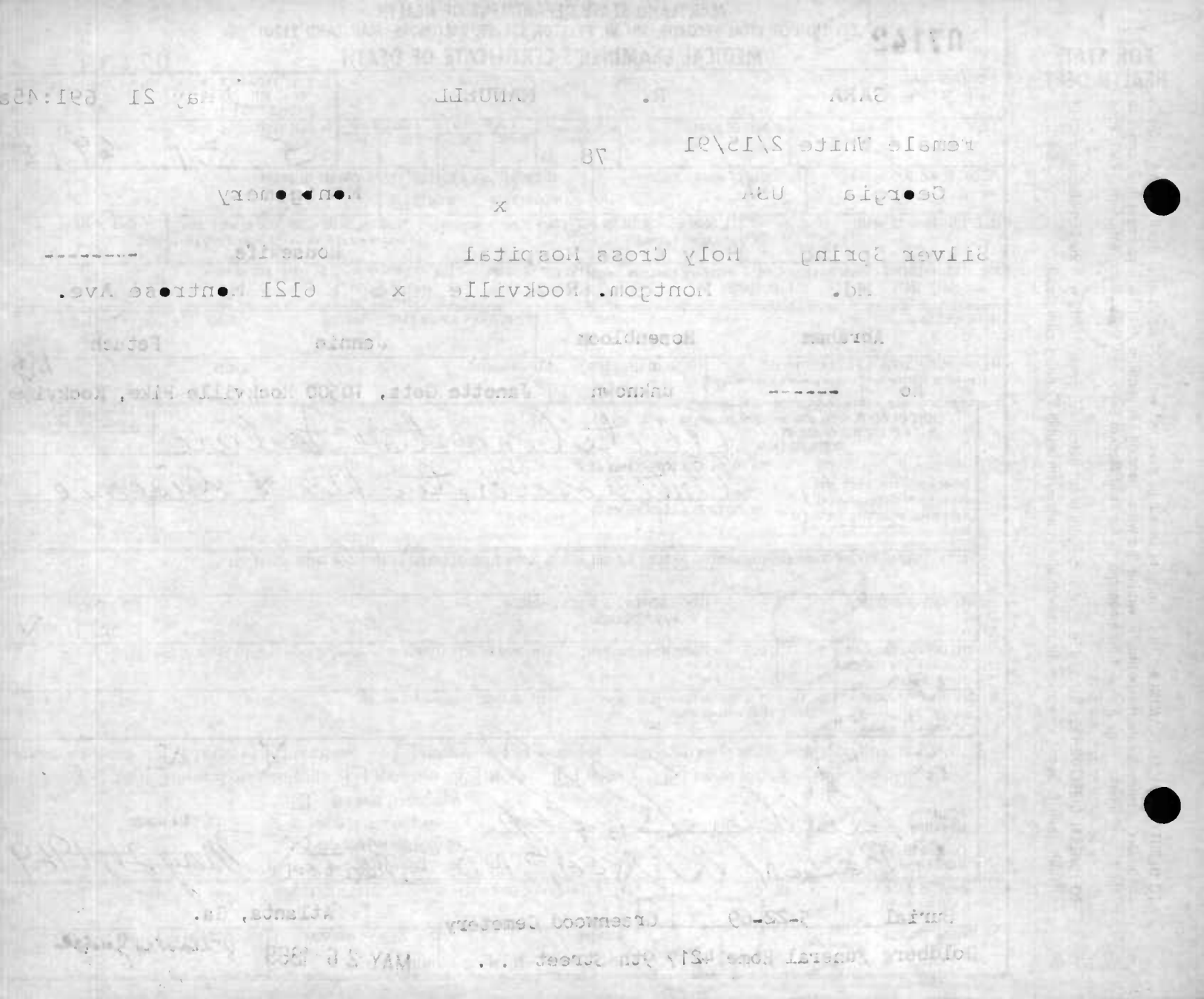
07138

1. DECEASED-NAME (Type or Print) <b>SARA</b>		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <b>May 21</b>		Month		Day		Year		2b. HOUR 1:45	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2/15/91</b>		6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS		DAYS		IF UNDER 24 HRS HOURS		MIN.		2c. DATE PRONOUNCED DEAD Month <b>5</b> Day <b>21</b> Year <b>69</b>	
7a. BIRTHPLACE (State or foreign country) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>											
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Montgom.</b>				13c. CITY OR TOWN <b>Rockville</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6121 Montrose Ave.</b>			
14. FATHER'S NAME <b>Abraham</b>				First				Middle				Last					
15. MOTHER'S MAIDEN NAME <b>Jennie</b>				First				Middle				Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. <b>unknown</b>				17. INFORMANT <b>Janette Getz</b>				ADDRESS <b>10500 Rockville Pike, Rockville</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4123</b> (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-----</b>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <b>Belden R. Reap</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>May 21, 1969</b>					
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>5-22-69</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Atlanta, Ga.</b>					
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home 4217 9th Street N.W.</b>								ADDRESS				25a. REC'D BY REGISTRAR DATE <b>MAY 26 1969</b>					
								25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07143

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

07139

1. DECEASED-NAME (Type or print) First Middle Last <i>Frank Belmont Marks</i>			2a. DATE OF DEATH Month Day Year <i>5 18 69</i>			2b. HOUR <i>3 P. M.</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>June 16, 1882</i>		6. AGE (In years last birthday) <i>86</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Balto., Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.				
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>617 Bennington Lane</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Ret. Pound Master D.C. Government</i>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>617 Bennington Lane</i>		
14. FATHER'S NAME First Middle Last <i>unk</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>unk</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>216-46-20139</i>		17. INFORMANT <i>Daughter</i>		Address <i>Silver Spring, Md</i> <i>617 Bennington Lane</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypostatic Pressure</i> <i>428X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Myocarditis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>14 days</i> <i>10 years</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>19</i> , 19 <i>54</i> , to <i>5/18</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5/19</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.										
22b. SIGNATURE <i>A.C. Leonardo</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/18/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>A.C. Leonardo</i>					22e. ADDRESS <i>5801 13th St., N.W., Washington, D. C.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 21, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Bladensburg, Pr. Geo. Maryland</i>				
24. FUNERAL DIRECTOR <i>C. Glen Carter</i>					ADDRESS <i>434 Georgia Avenue</i>		25a. REC'D BY REGISTRAR <i>MAY 22 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	
Warner E. Pumphrey, Inc., Silver Spring, Maryland										

SATO



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Page 15

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2151

3-29-88 8:00 PM

*[Faint handwritten notes]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 14-69  
45M

07144		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07140	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR	
MARTIN		Jacob		Month Day Year		5-4-69	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
MALE		Negro		12-9-89		79 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Md.		U.S.A.				Montgomery.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.		Montg.		Richville		13e. STREET AND NUMBER	
						1250 1st Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
First Middle Last		First Middle Last					
Winfield		MARTIN		Jennie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No				Carrie MARTIN		1250 1st Street	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Intracerebellar hemorrhage, right, spontaneous						3 days	
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						years	
(b) Cerebral arteriosclerosis							
DUE TO, OR AS A CONSEQUENCE OF							
(c) Hypertensive heart disease						years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Hypostatic broncho-pneumonia.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Apr 29, 1969, to May 4, 1969, that (I) (we) saw the deceased alive on May 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
J. S. S. S. S.		5-5-69		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		5/10/69		Poplar Grove Cem.		Quince Orchard, Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
R. K. Snowden		MAY 8 1969		William J. Jones			



2

THE STATE OF NEW YORK,  
COUNTY OF ALBANY,  
ss. I, the undersigned, Clerk of the Court,  
do hereby certify that the within and foregoing  
is a true and correct copy of the original  
as the same appears from the records of the  
Court.

Witness my hand and seal of office this 1st day of

X

Attest: *[Signature]*  
Clerk of the Court



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07145

CERTIFICATE OF DEATH

07141

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>601 Anderson Avenue</b>		d. STREET ADDRESS <b>601 Anderson Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Raymond LeRoy Martin</b>		4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1969</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1895</b>
9. AGE (In years) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Veterinarian</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry C. Martin</b>		14. MOTHER'S MAIDEN NAME <b>Olive Makely</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>216-46-1267-M</b>	
17. INFORMANT <b>Lillian May Martin - Wife</b>		Address <b>Maryland</b> <b>Box 107 Olney</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO <b>1419</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of mouth + Tongue</b> DUE TO <b>3 yrs</b> (c) <b>Emphysema</b> DUE TO <b>15 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>1961</b> , 19 to <b>5-18, 1969</b> , that (I) (we) last saw the deceased alive on <b>5-18, 1969</b> , and that death occurred at <b>10:00 P.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>W. G. Hall</b>		22b. DATE SIGNED <b>5-19-69</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. G. Hall</b>		22d. ADDRESS <b>615 Montgomery Ave., Rockville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/21/69</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		25a. REC'D BY REGISTRAR <b>May 21 1969</b>	
ADDRESS <b>Rockville, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Richard J. Gadsden</b>	

07145

STATE OF OHIO

IN SENATE

January 1, 1908

REPORT

OF THE

COMMISSIONERS

OF THE

LAND OFFICE

FOR THE YEAR

ENDING

DECEMBER 31, 1907

AND

ANNUAL REPORT

OF THE

LAND OFFICE

OF THE

STATE OF OHIO

FOR THE YEAR

1908

THE COMMISSIONERS OF THE LAND OFFICE

OF THE STATE OF OHIO

AND

THE

LAND OFFICE

OF THE

STATE OF OHIO

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STATE OF OHIO

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARTLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
07146					07142					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH					
Susie Mary Martin					Month 5 Day 21 Year 69 6 <sup>30</sup> AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		Negro		Dec. 10, 1896		72 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.		U.S.A.				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Rockville			331 Lincoln Ave			Housewife				
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Montg.		Rockville				331 Lincoln Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Richard Hebron			Susie Driver							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address				
No										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH CAUSED BY:										
IMMEDIATE CAUSE (a) Myocardial infarction										
DUE TO, OR AS A CONSEQUENCE OF										
(b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Chronic Pyelonephritis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 4-10-1969, to 5-21-1969, that (I) (we) last saw the deceased alive on 4-10-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE D. L. Bucy / S. N. Jones					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-21-69			
22d. PHYSICIAN'S NAME (Type) D. L. Bucy / S. N. Jones					22e. ADDRESS 809 Views Mill Rd Rockville Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		5/24/69		St Paul Cemetery		Sugarland Montg. Md.				
24. FUNERAL DIRECTOR Robert L. Snowden Rockville, Md.					25a. REC'D BY REGISTRAR DATE MAY 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

OFFICE OF THE ADJUTANT GENERAL

03148

TO: THE ADJUTANT GENERAL  
FROM: THE ADJUTANT GENERAL  
SUBJECT: [Illegible]

[Illegible text block]

[Illegible text block]

4109  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Ball Notified & approved

07147		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07143	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) First Middle Last ANN GERTRUDE MARTINEZ			2a. DATE OF DEATH Month Day Year MAY 31 1969		2b. HOUR 6:37PM
3. SEX FEMALE	4. RACE CAUCASIAN		5. DATE OF BIRTH 27 DEC 1904		6. AGE (In years last birthday) 64 YRS.
7a. BIRTHPLACE (State or foreign country) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH MONTGOMERY		Md.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. CITY OR TOWN LANHAN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13d. STREET AND NUMBER 9603 WELLINGTON ST					
14. FATHER'S NAME First Middle Last JAMES G BERRY		15. MOTHER'S MAIDEN NAME First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 579-24-5610		17. INFORMANT Address LANHAN, MD VIRGIN M HUMPHRIES 9603 WELLINGTON ST	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC- CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CARCINOMA OF THE CERVIX, STAGE IV					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (this hospital) attended the deceased from 30 MAY, 19 69, to 31 MAY, 19 69, that (we) lost saw the deceased alive on 31 MAY, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. L. HORTON, M.D.		22c. DATE SIGNED 1 JUN 69		22d. PHYSICIAN'S NAME (Type)	
22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/4/69		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	
23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA					
24. FUNERAL DIRECTOR GASCH FUNERAL HOME		ADDRESS HYATTSVILLE, MD		25a. REC'D BY REGISTRAR DATE JUN 5 1969	
25b. REGISTRAR'S SIGNATURE Alvin Judge					

THE  
OFFICE OF THE  
ATTORNEY GENERAL  
STATE OF NEW YORK  
ALBANY, N. Y.  
JANUARY 10, 1912  
TO THE  
COMMISSIONER OF THE  
LAND OFFICE  
SIR:  
I have the honor to acknowledge the receipt of your letter of the 1st inst. in relation to the above matter.  
In reply to inform you that the same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
J. D. [Signature]

RECORDED  
INDEXED  
JAN 11 1912



4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 171-1  
30M REV. 1-58

07148

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07144

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>Austin E Mayn</b>			2a. DATE OF DEATH Month Day Year <b>May 17 1969</b>		2b. HOUR <b>7:41 PM</b>
3. SEX <b>male</b>	4. RACE <b>caucasian</b>	5. DATE OF BIRTH <b>7/28/19</b>		6. AGE (In years last birthday) <b>49 YRS.</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>DC</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Silver Spring, Md</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hosp of SS.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Repairman</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spr.</b>	13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>4305 Ferrara Dr</b>
14. FATHER'S NAME First Middle Last <b>Charles Mayn</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Ammon Snoots</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service) <b>Yes WW II</b>		16b. SOCIAL SECURITY NO. <b>577-20-2759</b>	17. INFORMANT Address <b>Ann M. Mayn - 1354 Univ. Blvd., E., Hyattsville Md</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Anterograde Heart Disease Gross.</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>5-12</b> , 19 <b>69</b> , to <b>5-17</b> , 19 <b>69</b> , that (I) (we) just saw the deceased alive on <b>5-17-69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Morris Perry</b>				22c. DATE SIGNED <b>5-17-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Morris Perry</b>				22e. ADDRESS <b>11602 Georgia Ave., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 21, 1969</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Maryland</b>
24. FUNERAL DIRECTOR <b>C. Glen Carter Silver Spring, Maryland</b>			25a. REC'D BY REGISTRAR <b>Warner E. Pumphrey, Inc., 8434 Georgia Avenue</b>		25b. REGISTRAR'S SIGNATURE <b>Charles George</b>

259

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME										2a. DATE OF DEATH			2b. HOUR		
First			Middle			Last				Month		Day		Year	
Julia			Elizabeth			Mc Carty				May		11		1969	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female			White			Nov. 8, 1892			76			MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Indiana			U.S.A.						Montgomery						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Ashton						Housewife			Home						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER			
Md			Montgomery			Ashton									
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
First Middle Last			First Middle Last												
Othneil Hart Larivill			Bessie White												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (unknown) <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address						
No			577 42 6070			W. S. Thomas			1603 Revere Drive			Alexandra Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a)										24					
DUE TO, OR AS A CONSEQUENCE OF										2 hr					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										YRS					
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
			HOUR A.M. Month Day Year P.M. 19												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 5:33, to 4:41, 1969, that (I) (we) lost saw the deceased alive on 4/1/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE			22c. DATE SIGNED												
C. H. Ligon			5/14/69												
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS												
C. H. Ligon			Sandy Spring Md.												
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Removal			May 14 1969			Lake View			Hamilton Virginia						
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Francis H. Barber			Laytonsville Md			MAY 16 1969									

07143

White 1 female 1937 11 1939

White 1 female 1937 11 1939

White 1 female 1937 11 1939

White 1 female 1937 11 1939

White 1 female 1937 11 1939

White 1 female 1937 11 1939

White 1 female 1937 11 1939

White 1 female 1937 11 1939

White 1 female 1937 11 1939

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White 1 female 1937 11 1939

White 1 female 1937 11 1939

White 1 female 1937 11 1939

White 1 female 1937 11 1939

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VR A15 (4)  
30M REV. 1/68

07150		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07146			
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR	
First Middle Last William Howard McCauley						Month Day Year 5 19 69		9 15 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
MALE		White		1/26/07		62 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
D.C.		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hosp.		ass't treasurer - Nat'l Geograph Soc.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Silver Spring				1401 Crestridge Dr	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last							
Samuel H. McCauley		Nina Barrett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		----- yes		Elizabeth McCauley-1401 Crestridge Dr., S.S. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Abdominal fibrosarcoma								1 yr.	
1950 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 7-15-65, to 5-18-69, that (I) (we) saw the deceased alive on 5-18-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
G. G. Sengstack M.D.				5-19-69					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
G. G. Sengstack				9241 Columbia Blvd., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 21, 1969		Rockville Cemetery		Rockville, Montgomery, Maryland			
24. FUNERAL DIRECTOR				24b. DECEASED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Warner E. Pumphrey, Inc., 8434 Georgia Avenue				MAY 22 1969		G. Carlos Judge			



07150

William

Mr. J. W. J.

W. J.

W. J.

W. J.

W. J.

W. J.

W. J.

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W. J.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07151

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07147

1. DECEASED-NAME (Type or print) <i>Maude</i>			First <i>B</i> Middle <i>M</i> Last <i>McGinnick</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>25</i> Year <i>1969</i>			2b. HOUR <i>5:15 P.M.</i>					
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>July 12, 1880</i>			6. AGE (In years lost birthday) <i>88</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Michigan</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Wren, Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Brooke Grove Foundation</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Bethesda</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>6106 Bradley Blvd.</i>		
14. FATHER'S NAME <i>James</i>			First <i>A</i> Middle <i>Beerman</i> Last			15. MOTHER'S MAIDEN NAME <i>Eliza</i>			First <i>Knight</i> Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>523-32-9648</i>			17. INFORMANT <i>NURSING HOME RECORDS -</i>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4124 Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>lost.</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>June, 1967</i> , to <i>May 25, 1969</i> , that (I) (we) last saw the deceased alive on <i>May 25, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Frederick Mooman</i> MD			22c. DATE SIGNED <i>May 25, 1969</i>			22d. PHYSICIAN'S NAME (Type) <i>Frederick Mooman</i>			22e. ADDRESS <i>Medical Center, Sandy Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>			23b. DATE <i>5-26-1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>George Washington University Medical School-Anatomical</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>					
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SON, INC.</i>			25a. REC'D BY REGISTRAR <i>MAY 28 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								

07151

INSTITUTION OF ORIGIN

FOR THE RECORD IN CONNECTION WITH THE INVESTIGATION OF THE CASE

Prepared by

George Washington University  
Medical School-Anatomical

Washington, D.C.

1-20-1939

Received

Box 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

07152

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07148

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <i>Antoinette McCallough</i>			2a. DATE OF DEATH Month Day Year <i>May 4 1969</i>			2b. HOUR M <i>9:25</i>				
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>6/9/24</i>		6. AGE (In years last birthday) <i>44</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.				
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Administrative</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Govt.</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>735-5190 Ave.</i>		
14. FATHER'S NAME First Middle Last <i>Milton Padagas</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Eudokia Kovis</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>577-26-6123</i>		17. INFORMANT Address <i>Lawrence McCallough, same as above</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> <i>5710</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Esophageal varices, ruptured</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cirrhosis, Laennec's</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/13</u> , 19 <u>69</u> , to <u>5/1</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Frederick Y. Donn</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/1/1969</i>			
22d. PHYSICIAN'S NAME (Type) <i>Frederick Y. Donn</i>					22e. ADDRESS <i>10400 Conn. Ave., Kensington, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 5, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Snitland, Maryland</i>				
24. FUNERAL DIRECTOR <i>Glen Carter</i>					ADDRESS <i>Silver Spring, Maryland</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	
26. FUNERAL HOME <i>Warner E. Pumphrey, Inc.</i>					ADDRESS <i>8434 Georgia Avenue</i>					

07152

CERTIFICATE OF DEATH

(Name)

1911-1912

1911-1912

1911-1912

1911-1912

1

1911-1912

1911-1912

# FOR-STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07153

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07149

1. DECEASED NAME (Type or Print) <b>Steven</b> First <b>Thomas</b> Middle <b>Mc Bhee</b> Last			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <b>5 17 1969</b>			2b. HOUR <b>10:05 P.M.</b>									
3. SEX <b>M.</b>		4. RACE <b>W.</b>		5. DATE OF BIRTH <b>May 26, 1954</b>		6. AGE (In years last birthday) <b>14 YRS.</b>		2c. DATE PRONOUNCED DEAD <b>May 17 1969</b>		2d. HOUR <b>10:05 P.M.</b>					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b>						
10. CITY OR TOWN OF DEATH <b>Derwood.</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>5924 Muncaster Mill Rd.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Montgomery</b>				13c. CITY OR TOWN <b>Derwood</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER <b>5924 Muncaster mill rd.</b>			
14. FATHER'S NAME First <b>Carl W.</b> Middle <b>Mc Bhee</b> Last				15. MOTHER'S MAIDEN NAME First <b>Joanne</b> Middle <b>Doucette</b> Last											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot Wound of Head -</b> <b>9229</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>10:05 P.M. 5/17 1969</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>When playing with guns with boy friend shot accidentally</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>				21f. LOCATION Street or R.F.D. No. <b>5924 Muncaster Mill Rd.</b> City or Town <b>Derwood</b> County <b>Montgomery</b> State <b>Md.</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>John G. Ball</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>May 18, 1969</b>							
EXAMINER'S NAME (Type) <b>John G. Ball</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>May 21 1969</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville</b>				23d. LOCATION (City or Town) (County) (State) <b>Laytonsville Mont. Md.</b>			
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>				ADDRESS <b>Laytonsville Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 22 1969</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



07153

Steven

stressed

stressed

John G. Hall

MAY 2 1969

Francis A. Carter  
Lafayette, La.  
May 21 1969  
Lafayette, La.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15  
45M 5/27/69

07154										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07150														
1. DECEASED-NAME (Type or print) Paul T. McHenry McHenry										2a. DATE OF DEATH Month May Day 22 Year 1969										2b. HOUR M														
3. SEX Male					4. RACE White					5. DATE OF BIRTH Sept 11, 1900					6. AGE (In years last birthday) 68 YRS.					IF UNDER 1 YEAR MONTHS					IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland					7b. CITIZEN OF WHAT COUNTRY? U. S. A					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Montgomery Md.																			
10. CITY OR TOWN OF DEATH Bethesda, Md					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Realtor					12b. KIND OF BUSINESS OR INDUSTRY Real Estate																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va.					13b. COUNTY Berkley Springs					13c. CITY OR TOWN Berkley Springs					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER 208 Wilkes S Berkley Springs, W. Va.														
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 217-24-8304					17. INFORMANT Berkley Springs, W. Va. Mrs. Evelyn McHenry, 208 Wilkes St.									
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD c 2 prior myocardial infarctions</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4109										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 15 yrs.																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																								
22a. I certify that (I) (this hospital) attended the deceased from 5-8-69, 19 to 5-22, 1969, that (I) (we) lost saw the deceased alive on May 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																		
22b. SIGNATURE Frederick Mooman MD										22c. DATE SIGNED 5-23-69					22d. PHYSICIAN'S NAME (Type) Frederick Mooman					22e. ADDRESS Suburban Hospital, Bethesda, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 5/26/69					23c. NAME OF CEMETERY OR CREMATORY Linden-Linthicum					23d. LOCATION (City or Town) (County) (State) Clarksville, Maryland																			
24. FUNERAL DIRECTOR Howard County Funeral Home of Harry Witzke										ADDRESS Ellicott City Maryland										25a. REC'D BY REGISTRAR MAY 27 1969					25b. REGISTRAR'S SIGNATURE Charles J. J...									

07152

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1903

REPORT

1892

OF THE

MAY 27 1893

1892

REPORT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07151

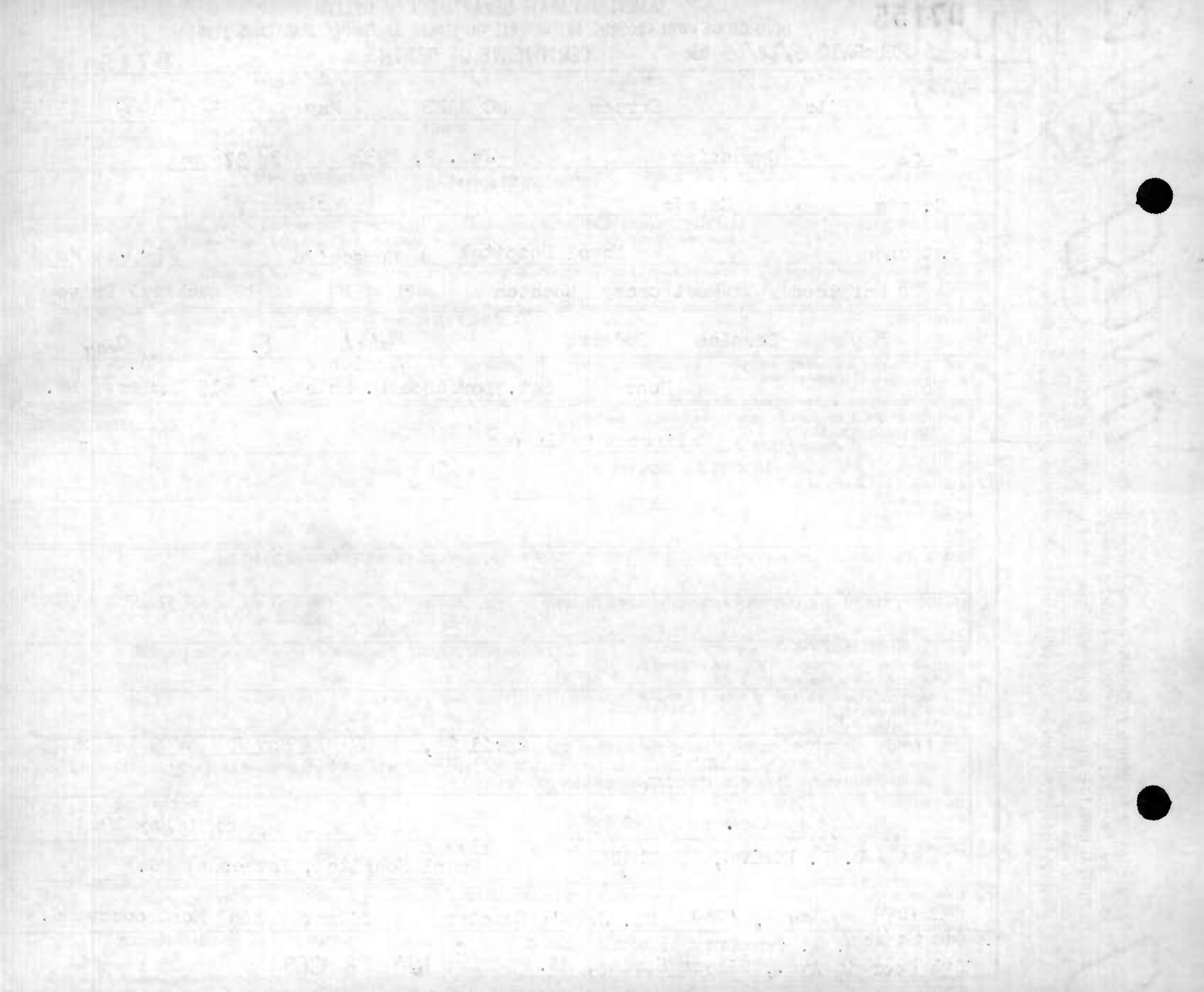
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 Film 412 5/12/69 kk

CERTIFICATE OF DEATH

07151

1. DECEASED-NAME (Type or print) First Middle Last Rita Doreen MC NABB			2a. DATE OF DEATH Month Day Year May 3 1969		2b. HOUR 1145 M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH Jul. 3, 1931		6. AGE (In years last birthday) 32 37 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Canada	7b. CITIZEN OF WHAT COUNTRY? Canada	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Wheaton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 10815 Bucknell Drive	
14. FATHER'S NAME First Middle Last Roy Douglas Rodgers			15. MOTHER'S MAIDEN NAME First Middle Last Mabel E. Troy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Md. Wheaton Sgt. Lawrence G. McNabb, 10815 Bucknells Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Mellanoma 1729 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from April 23, 1969, to May 3, 1969, that (1) (we) last saw the deceased alive on May 3, 1969, and that in (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. L. Horton, MD		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 6 May 1969	
22d. PHYSICIAN'S NAME (Type) D. L. HORTON, LT MC USNR		22e. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 8, 1969	23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Montgomery, Md.	
24. FUNERAL HOME H. E. Pumphrey Funeral Home 8434 Georgia Ave., Silver Spring, Md.		25a. REC'D BY REGISTRAR MAY 8 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



1538  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1-69

07156

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07152

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First MARY	Middle PHILOMENA	Lost MEAGHER	2a. DATE OF DEATH Month 5 Day 26 Year 69		2b. HOUR 1:15 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 8/27/1897		6. AGE (In years lost birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Phila., Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Wheaton, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nurs. Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Filing systems clerk		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE District of Columbia		13b. COUNTY 13c. CITY OR TOWN Wash		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1735. New Hampshire ave				
14. FATHER'S NAME John nm Meagher		15. MOTHER'S MAIDEN NAME Catherine Kelleher		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no					17. INFORMANT Catherine Crawford.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Colon</u> 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Jan 1969, to 5/18, 1969, that (I) (we) last saw the deceased alive on 5/18 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE W. Tabb Moore				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/26/69				
22d. PHYSICIAN'S NAME (Type) Tabb Moore, M.D.				22e. ADDRESS 2001 I St., NW, Washington, DC						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5.28.69		23c. NAME OF CEMETERY OR CREMATORY Whitemarsh.Memo.Park		23d. LOCATION (City or Town) (County) (State) Prospectville. Penna				
24. FUNERAL DIRECTOR Lee Funeral Home 3004 4th St Wash DC				25a. REC'D BY REGISTRAR DATE MAY 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

07152

SECTION OF DEPT.

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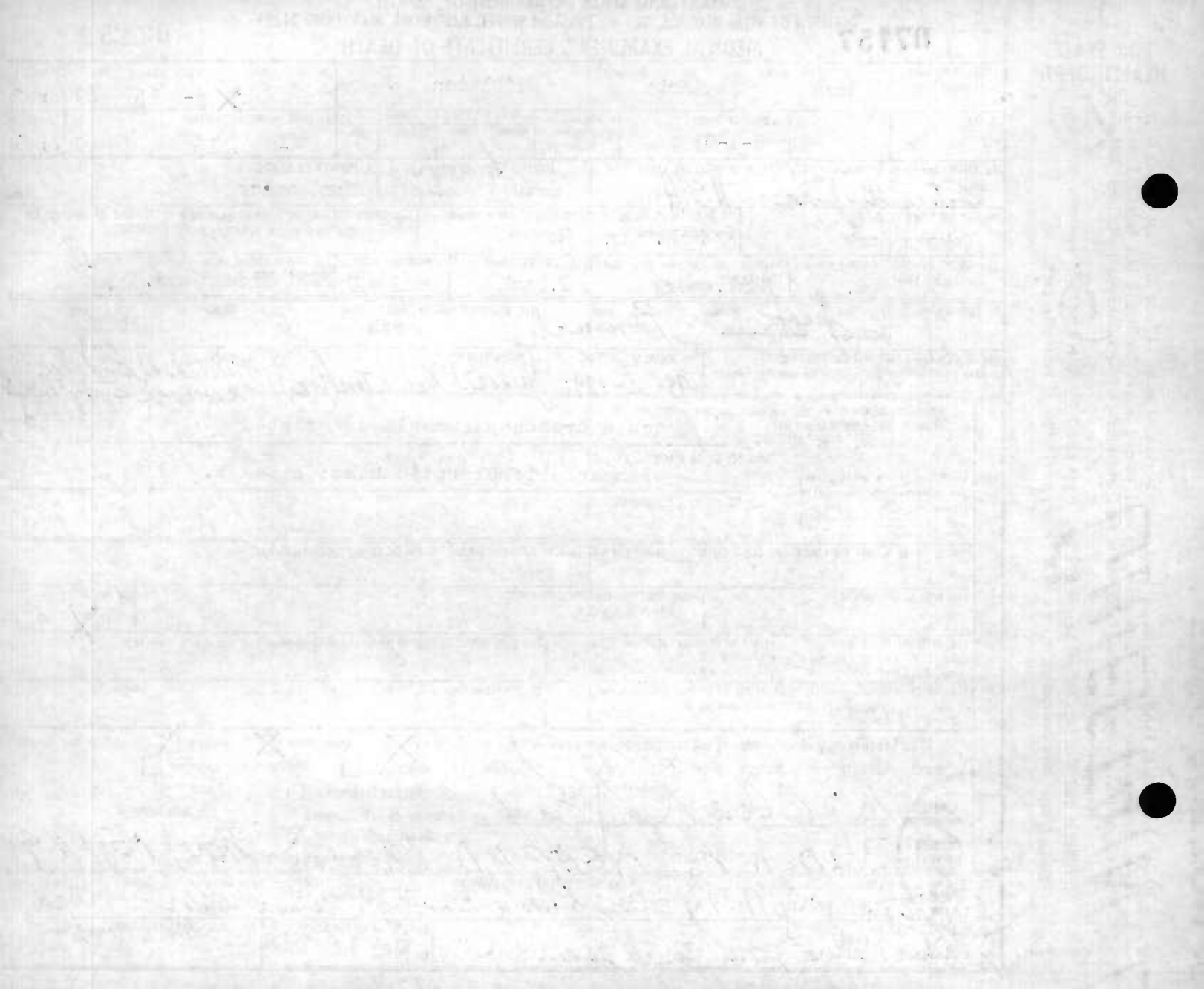
# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First Rose	Middle Marie	Lost Middleton	2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5- 15 1969			2b. HOUR 2:48 P.M.
3. SEX F	4. RACE W	5. DATE OF BIRTH 8-4-03		6. AGE (In years last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS		2c. DATE PRONOUNCED DEAD Month 5- Day 13 Year 1969	
7a. BIRTHPLACE (State or foreign country) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San & Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN T. Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8221 Flower Ave.
14. FATHER'S NAME First Middle Lost Jacob Bonheur Bonner		15. MOTHER'S MAIDEN NAME First Middle Lost Sarah Gottlieb		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				
16b. SOCIAL SECURITY NO. 518-36-1891		17. INFORMANT James T. Middleton (son) New York City N.Y.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>485X</u> Acute bronchopneumonia associated DUE TO, OR AS A CONSEQUENCE OF with arteriosclerotic heart disease. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden R. Reap		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED May 15, 1969		
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town or county) 254 Cornell Rd N.W.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE May 19, 1969		23c. NAME OF CEMETERY OR CREMATORY Soul Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Calmar Manor Md.		
24. FUNERAL DIRECTOR Arthur Wallers				ADDRESS 254 Cornell Rd N.W.C.		25a. REC'D BY REGISTRAR MAY 19 1969		25b. REGISTRAR'S SIGNATURE H. [Signature]



## CERTIFICATE OF DEATH

07158

07154

1. DECEASED-NAME (Type or print) <b>George P. Miller</b>			2a. DATE OF DEATH Month <b>5</b> Day <b>3</b> Year <b>69</b>			2b. HOUR <b>M</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>7-10-02</b>		6. AGE (In years last birthday) <b>66</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montg. County</b> Md.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Consultant-Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>G.S.A.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Fulton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>Reservoir Road, Fulton, Md.</b>		14. FATHER'S NAME First <b>George</b> Middle <b>P.</b> Last <b>Miller</b>		15. MOTHER'S MAIDEN NAME First <b>Bertha</b> Middle <b>Jack</b> Last <b>Md.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>339-09-8322-A</b>		17. INFORMANT <b>Mrs. Jeanne Miller, Reservoir Road, Fulton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> <b>162.1</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anaplastic Alveolar Cell Adenocarcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 1969</b> , to <b>3 MAY 1969</b> , that (I) (we) last saw the deceased alive on <b>3 May 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Richard Compton MD</b>				22c. DATE SIGNED <b>4 May 69</b>			
22d. PHYSICIAN'S NAME (Type) <b>J. RICHARD COMPTON</b>				22e. ADDRESS <b>612 MAIN ST. LAUREL, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 6, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Mont. Maryland</b>	
24. FUNERAL DIRECTOR <b>Paul Smith &amp; Son</b>				25a. REC'D BY REGISTRAR <b>Warner E. Pumphrey, Inc.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Xenograft carcinoma  
nephritic involvement

398

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
GLADYS D.				MILLER	MAY Month 28 Day Year 1969	12:15 PM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS
Female	Caucasian		8/11/96		72 YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Penn.	U.S.A.				Montgomery Md.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring	Holy Cross Hospital		Retired Royal Typewriter Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. CITY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Md.	Montgomery		Silver Spring		1400 Fenwick Lane	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	
William Davies					-----	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		
		578-26-3114		12701 Barbara Rd. William A. Berlew-Wheaton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) 3940 Congestive Heart Failure						8 months
DUE TO, OR AS A CONSEQUENCE OF (b) MITRAL STENOSIS with Insufficiency						Years?
DUE TO, OR AS A CONSEQUENCE OF (c) RHEUMATIC HEART DISEASE						Years?
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
SEVERE ARTERIOSCLEROSIS AND CORONARY DISEASE						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
	HOUR A.M. Month Day Year P.M. 19					
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION			
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work			Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May 12, 1969, to May 27, 1969, that (I) (we) lost saw the deceased alive on May 27, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE		22c. DATE SIGNED				
Hubert G. Graziani MD		5/28/69				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
Hubert G. Graziani MD		10101 GEORGIA AVE. S.E. MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
burial	5/31/69	Ft. Lincoln Cemetery		Prince Georges County, Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
THE S.H. HINES CO.		2901 14th ST. NW		JUN 2 1969	Richard Judge	

07153

UNITED STATES OF AMERICA

CLAYTON S. MILLER

Female, Caucasian - 8/11/95

DOB: 8/11/95

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]

POB: [illegible]



1519

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07160		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07156	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	
Rudolph			L		Miller	Month	Day
						Year	2b. HOUR
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR
Male			White		3/16/198	71	MONTHS
						YRS.	DAYS
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH
Iowa			USA				Montgomery
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
Bethesda			Suburban Hosp.			Retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
DC					Washington		6612 Barnaby St. N.W.
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	
Paul			L		Miller	Emma	C Anderson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address
Yes			577-58-3769		Wife Esther Miller		Same as above #13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) 1519							4 months
DUE TO, OR AS A CONSEQUENCE OF							1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Carcinomatosis (generalized)							
DUE TO, OR AS A CONSEQUENCE OF							
(c) Carcinom of Stomach.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)			
		HOUR A.M. Month Day Year P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State			
				Feb 59, to May 29, 1969			
22a. I certify that (I) (this hospital) attended the deceased from Feb 59, to May 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
Michel M. Healy MD		5/29/69		MICHEL M. HEALY			
22e. ADDRESS		22f. ADDRESS					
5411 CEDAR LA., BETH., MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		6/2/69		ROCK CREEK CEM.		WASHINGTON, D.C.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
JOS. GAWLER'S SONS, 5130 WIS. AVE, WASH., D.C.				JUN 5 1969		K. Jones	

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
Aletha			Ewalt		Maedy		MAY		Month 4 Day 1969 Year		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		2b. HOUR		
Female		White		Sept. 7, 1881			87 YRS.		5 <sup>45</sup> M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
KANSAS		USA				Montgomery					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring			Colonial Villa			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Montgomery		Woodacres				6008 Cobalt Rd.		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
Richard Thornton			Ewalt						Adeline Holten Martin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No			578-62-9572		Mrs. Bert W. Morrow		6008 Cobalt Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Carcinomatosis, type undetermined</i>										6 mos.	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <i>1991</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<i>1) Diabetes mellitus 2) Arteriosclerosis 3) Anemia</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work											
22a. I certify that (I) (this hospital) attended the deceased from <i>1948</i> to <i>May 4, 1969</i> , that (I) (we) last saw the deceased alive on <i>May 4, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
<i>Joseph J. Wallace M.D.</i>		<i>May 4, 1969</i>									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
JOSEPH J. WALLACE, M.D.		1302 18TH ST. N.W. WASH. DC 20036									
23a. BURIAL, CREMATION, (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Buried		5-6-69		Parklawn		Rockville		Mont.		Md.	
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey				7557 Wisc. Beth. Md.				MAY 12 1969		<i>Charles J. Jones</i>	

07101

CERTIFICATE OF DEATH

OFFICE OF THE REGISTRAR, DISTRICT OF COLUMBIA

Full Name of Deceased Alfred E. Smith

Age 45 Sex M Date of Birth May 1, 1901

Place of Birth Washington, D.C. Cause of Death Heart Disease

Occupation Engineer Date of Death May 15, 1946

Place of Death Home Signature of Registrar [Signature]

Official Seal of the District of Columbia

Witnessed by [Signature] and [Signature]

Filed for Record May 20, 1946

Index Number 100-100000-100000

Remarks [Blank]

Signature of Deceased [Blank]

Signature of Next of Kin [Blank]

Signature of Physician [Blank]

Signature of Coroner [Blank]

Signature of Burial Officer [Blank]

Signature of Undertaker [Blank]

Signature of Funeral Home [Blank]

Signature of Cemetery [Blank]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

17

07162

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07158

1. DECEASED-NAME (Type or print) <i>Ann M. MOON</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>9</i> Year <i>1969</i>			2b. HOUR <i>2:00 PM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>March 24, 1887</i>		6. AGE (In years last birthday) <i>82</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>415 Silver Spring Ave.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>415 Silver Spring Ave. #405</i>	
14. FATHER'S NAME First <i>John</i> Middle <i>C.</i> Last <i>Cavanaugh</i>			15. MOTHER'S MAIDEN NAME First <i>Joan</i> Middle <i>-</i> Last <i>Lynch</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Miss Jane Moon-415 Silver Spring Ave. S.S. Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ARTERIOSCLEROTIC HEART DISEASE</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>YRS.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>2/1</i> , 19 <i>67</i> , to <i>5/9</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5/8</i> , 19 <i>67</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R.T. Benack MD</i> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/9/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>R.T. Benack MD</i>				22e. ADDRESS <i>4115 Colie Drive, Wheaton, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 12, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Montgomery, Md.</i>			
24. FUNERAL DIRECTOR <i>Warner E. Humphrey, Inc., 8434 Georgia Avenue</i>				25a. REC'D BY REGISTRAR <i>MAY 14 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J. C. Jones</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07163

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07159

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Hughes</b>			First <b>Louis</b>			Middle <b>Moore</b>			Last			2a. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1969</b>			2b. HOUR <b>7:40</b> A <b>M</b>		
3. SEX <b>Male</b>			4. RACE <b>Negro</b>			5. DATE OF BIRTH <b>7 October 1916</b>			6. AGE (In years lost birthday) <b>52</b> YRS.			IF UNDER 1 YEAR MONTHS <b>52</b> DAYS <b>52</b>			IF UNDER 24 HRS. HOURS <b>52</b> MIN. <b>52</b>		
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.								
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and number) <b>The Clinical Center</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Construction</b>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Connecticut</b>			13b. COUNTY <b>Stamford</b>			13c. CITY OR TOWN <b>Stamford</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>94 Henry Street</b>					
14. FATHER'S NAME <b>Andrew</b>			First <b>T.</b>			Middle <b>Moore</b>			Last			15. MOTHER'S MAIDEN NAME <b>Mary</b>			First <b>Jane</b> Middle <b>Evans</b> Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>237-09-2488</b>			17. INFORMANT <b>The Medical Records</b> address <b>The Clinical Center, NIH, Bethesda, Md. 20014</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia and mediastinitis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Dissecting aneurysm, thoracic aorta</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4410</b>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 Years</b> <b>2 Years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Atherosclerotic cardio-vascular disease</b>																	
19a. DATE OF OPERATION <b>28 Apr. 69</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Dissecting Aneurysm</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>5 March</b> , 19 <b>69</b> , to <b>3 May</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>3 May</b> , 19 <b>69</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.																	
22b. SIGNATURE <b>Bradley M. Rodgers, MD</b> DEGREE <b>MD</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>															22c. DATE SIGNED <b>3 May 1969</b>		
22d. PHYSICIAN'S NAME (Type) <b>BRADLEY M. RODGERS</b>						22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>5-6-69</b>			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State) <b>Stamford, Conn.</b>								
24. FUNERAL DIRECTOR <b>W. W. Chambers</b> ADDRESS <b>1400 Chapin St. N.W. D.C.</b>						25a. REC'D BY REGISTRAR DATE <b>MAY 6 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Richard Judge</b>								

OFFICE OF THE ATTORNEY GENERAL

1. Name of the person or entity: [illegible]  
2. Address: [illegible]  
3. City: [illegible]  
4. State: [illegible]  
5. Zip: [illegible]  
6. Date of birth: [illegible]  
7. Date of death: [illegible]  
8. Date of entry: [illegible]  
9. Date of exit: [illegible]  
10. Date of return: [illegible]

11. Name of the person or entity: [illegible]  
12. Address: [illegible]  
13. City: [illegible]  
14. State: [illegible]  
15. Zip: [illegible]  
16. Date of birth: [illegible]  
17. Date of death: [illegible]  
18. Date of entry: [illegible]  
19. Date of exit: [illegible]  
20. Date of return: [illegible]

21. Name of the person or entity: [illegible]  
22. Address: [illegible]  
23. City: [illegible]  
24. State: [illegible]  
25. Zip: [illegible]  
26. Date of birth: [illegible]  
27. Date of death: [illegible]  
28. Date of entry: [illegible]  
29. Date of exit: [illegible]  
30. Date of return: [illegible]

31. Name of the person or entity: [illegible]  
32. Address: [illegible]  
33. City: [illegible]  
34. State: [illegible]  
35. Zip: [illegible]  
36. Date of birth: [illegible]  
37. Date of death: [illegible]  
38. Date of entry: [illegible]  
39. Date of exit: [illegible]  
40. Date of return: [illegible]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07164

07160

1. DECEASED-NAME (Type or Print) <i>Joseph Michael Morel</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>5</i> Day <i>23</i> Year <i>1969</i>			2b. HOUR <i>2:48</i> P.M.			
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>2/9/1921</i>	6. AGE (In years last birthday) <i>48</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>May</i> Day <i>23</i> Year <i>1969</i>			2d. HOUR <i>2:48</i> P.M.
7a. BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Ray Tech</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Fredricks Mt. Aug</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>701 main St.</i>		
14. FATHER'S NAME First <i>Louis</i> Middle <i>Morel</i> Last <i>Morel</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Centofant</i> Last <i>Centofant</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>			16b. SOCIAL SECURITY NO. <i>W.W. 2 115-05-8775</i>		17. INFORMANT <i>Wife Marjorie Morel</i>			ADDRESS <i>above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Injuries Severe.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>8120</i> (b) <i>Trauma from Auto Accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <i>8:00 PM 5/23 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Car he was driving was struck by another auto</i>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway 70 S.</i>		21f. LOCATION Street or R.F.D. No. <i>2 miles South of Montrose - Rockville</i>		City or Town <i>Montgomery</i> County <i>Md</i> State <i>Md</i>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>May 23, 1969</i>			
EXAMINER'S NAME (Type) <i>John G. Ball, M.D.</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 26, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Michaels</i>		23d. LOCATION (City or Town) (County) (State) <i>Poplar Springs, Md.</i>			
24. FUNERAL DIRECTOR <i>Olin L. Molesworth, Damascus, Md.</i>					25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
DATE <i>MAY 28 1969</i>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07165		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07161			
1. DECEASED-NAME (Type or print) First Middle Last Rosa Morris				2a. DATE OF DEATH May Month 14 Day 1969			2b. HOUR 12:05		
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH 4/12/74		6. AGE (In years lost birthday) 95 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carriage Hill N. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7333 New Hampshire Ave.	
14. FATHER'S NAME First Middle Last Nathan Wollberg		15. MOTHER'S MAIDEN NAME First Middle Last Rosalia Abbott							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes, no, or unknown		16b. SOCIAL SECURITY NO. 579148179-D		17. INFORMANT Mrs. Helen Rubenstein		Address 7333 N. H. Ave. Takoma Park, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Congestive heart failure due to</u>									
4123 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) <u>Atherosclerotic heart disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>5 Jan</u> , 19 <u>69</u> , to <u>14 May</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>13 May</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Donald B. Doty M.D.</u>				DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>14 May 69</u>	
22d. PHYSICIAN'S NAME (Type) Donald B. Doty, M. D.				22e. ADDRESS 1909 Hanover Street, Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 16, 1969		23c. NAME OF CEMETERY OR CREMATORY Home of Peace Cemetery		23d. LOCATION (City or Town) (County) (State) Alexandria, Virginia			
24. FUNERAL DIRECTOR Donald M. Stein				ADDRESS 232 Carroll St., N.W. Wash., D.C.		25a. REC'D BY REGISTRAR MAY 19 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



07160

CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY A PHYSICIAN OR OTHER PERSON QUALIFIED TO JUDGE OF THE CAUSE OF DEATH

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of death: \_\_\_\_\_

5. Place of death: \_\_\_\_\_

6. Cause of death: \_\_\_\_\_

7. Signature of physician: \_\_\_\_\_

8. Signature of registrar: \_\_\_\_\_

9. Signature of informant: \_\_\_\_\_

10. Signature of witness: \_\_\_\_\_

11. Signature of funeral director: \_\_\_\_\_

12. Signature of undertaker: \_\_\_\_\_

13. Signature of cemetery: \_\_\_\_\_

14. Signature of church: \_\_\_\_\_

15. Signature of family: \_\_\_\_\_

16. Signature of friends: \_\_\_\_\_

17. Signature of neighbors: \_\_\_\_\_

18. Signature of community: \_\_\_\_\_



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07166

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07162

1. DECEASED-NAME (Type or Print)		First <b>Mary</b>		Middle <b>Haje</b>		Last <b>Moses</b>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>5</b> Day <b>25</b> Year <b>1969</b>		2b. HOUR <b>6:05</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2-5-11</b>		6. AGE (In years last birthday) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Lebanon</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Naturalized USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.					
10. CITY OR TOWN OF DEATH <b>Cherry Chase</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>8801 Montgomery Ave</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Beautician</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Cherry Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>8801 Montgomery Ave</b>			
14. FATHER'S NAME First <b>Charles</b> Middle <b>Haje</b> Last <b>Haje</b>		15. MOTHER'S MAIDEN NAME First <b>Shamus</b> Middle <b>Savid</b> Last <b>Savid</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-09-8582</b>		17. INFORMANT <b>BROTHER</b> ADDRESS <b>George H. Haje - 10021 Tenbrook Spire</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4109</b> (b) <b>Coronary arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>John G. Ball</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>May 26, 1969</b>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-29-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Rockville, Montgomery Co., Md.</b>			
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SON, INC.</b> 5130 WISC. AVE., N. W. WASH., D. C. 20016						25a. REC'D BY REGISTRAR <b>DAUN 2 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>			

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Rockville, Montgomery Co., Md.

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**FOR STATE  
HEALTH DEPT.**

07167

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07163

1. DECEASED-NAME (Type or Print) <b>JOHN WILLIAM MULLENS</b>			First Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>May 5 1969</b>			2b. HOUR <b>8:45 PM</b>				
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>11-18-14</b>	6. AGE (In years lost birthday) <b>54</b> YRS.	IF UNDER 1 YEAR MONTHS <b>5</b> DAYS <b>17</b>	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <b>May</b> Year <b>1969</b>			2d. HOUR <b>8:45 PM</b>				
7a. BIRTHPLACE (State or foreign country) <b>Ala.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery Md.</b>							
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. San. &amp; Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Manager --- Workshop for Blind</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Wheaton</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3920 Lantern Dr.</b>					
14. FATHER'S NAME <b>B. W. Mullens</b>				First Middle Last		15. MOTHER'S MAIDEN NAME <b>Ida Bridges</b>				First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Hospital Records</b>				ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Intestinal Obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>A. S. H. Dis. with old myocardial infarction</b>													
19a. DATE OF OPERATION <b>May 5, 1969</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Intest. Obstruction</b>				20. AUTOPSY? <b>YES</b> <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE-WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Belden R. Reap</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>May 6, 1969</b>				
EXAMINER'S NAME (Type) <b>Belden R. Reap, MD</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town or county) <b>Wheaton</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>5/5/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Darnestown</b>			23d. LOCATION (City or Town) (County) (State) <b>Darnestown, Montgomery, Md.</b>					
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home Rockville, Maryland</b>						25a. REC'D BY REGISTRAR <b>MAY 9 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07-10

MEMORANDUM FOR THE RECORD

07-10

TO : [illegible]  
FROM : [illegible]  
SUBJECT : [illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum body.]

4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07168									
07164									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Dollie			Adelaide			Murnan			5 Month 27 Day 69 Year 9:50pm
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Female		White		11-9-90		78 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
New Jersey		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Montgomery General		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Silver Spring				3551 S. Leisure Wld. Blvd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
George			Bierach			Adelaide Clering			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no			578-05-6822		Medical Records		Montgomery General Olney, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 4109 Cardiac Arrest								20 min.	
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction								1 day.	
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary-Arteriosclerotic Heart Disease								years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)									
Diabetes Mellitus.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
				Sept 19 66, to May 19 69, that (I) (we) last saw the deceased alive on May 27 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
Richard A. Yates, MD		5/28/69.		Old Baltimore Rd., Olney, Md. 20832					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation		5.29.69		Lee's Crematory		Washington D.C.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Lee Funeral Home 300.4th st N E				JUN 2 1969		Richard A. Yates			

20150



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

07169		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07165	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last Warren T. Murphy			2a. DATE OF DEATH Month Day Year May 12 1969			2b. HOUR 1:15 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 12-12-03		6. AGE (In years last birthday) 65 YRS.	
7a. BIRTHPLACE (State or foreign country) Calif		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agri	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE M.D.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 6207 CATHARINE LANE		14. FATHER'S NAME First Middle Last James J. Murphy		15. MOTHER'S MAIDEN NAME First Middle Last Orrie L. Tuttle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 577-60-1672		17. INFORMANT Eliz P. Murphy-		Address Same.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Thrombosis. Old & Recent 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis old & Recent- DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Arterio Sclerosis Severe - years -						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes. Melitus -							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1950, to May 1969, that (I) (we) last saw the deceased alive on 6 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John G. Ball MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED May 12, 1969	
22d. PHYSICIAN'S NAME (Type) John G. Ball				22e. ADDRESS Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Burial-Removal 5-13-1969		23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery		23d. LOCATION (City or Town) (County) (State) Oakland, California	
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC. ADDRESS 5130 WISC. AVE., N. W. WASH., D. C. 20016				25a. REC'D BY REGISTRAR MAY 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

03180

OFFICE OF DEATH

1

Residence, Maryland

Removal - 1-1-1959 Mountain View Cemetery, Oakland, California

4124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07170

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07166

1. DECEASED-NAME (Type or print) First Middle Last <u>Rose Elizabeth Nichol</u>			2a. DATE OF DEATH Month Day Year <u>May 22 1969</u>			2b. HOUR <u>P. M.</u>			
3. SEX <u>FEMALE</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH <u>9-10-94</u>		6. AGE (In years last birthday) <u>74</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>Calif.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.			
10. CITY OR TOWN OF DEATH <u>TAKOMA Park</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>WASH. San &amp; Hosp</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery Tak. Pk</u>		13c. CITY OR TOWN <u>Tak. Pk</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>5310 Greenwood Ave</u>	
14. FATHER'S NAME First Middle Last <u>JAMES Macklin</u>		15. MOTHER'S MAIDEN NAME First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <u>Wash. San. &amp; Hosp. Records.</u>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Cerebral Hemorrhage</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 yrs</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , to <u>May 22, 1969</u> , that (I) (we) last saw the deceased alive on <u>May 22 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u> M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5-22-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>F. WHITLOCK</u>				22e. ADDRESS <u>2717 Canadian Takoma Park, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE <u>May 27 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Washington Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Adephi. P. Dea Md.</u>			
24. FUNERAL DIRECTOR <u>Whitlock's Washington, D.C. 20012</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>MAY 27 1969</u>									

87130

OFFICE OF DEATH

87130

87130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07171

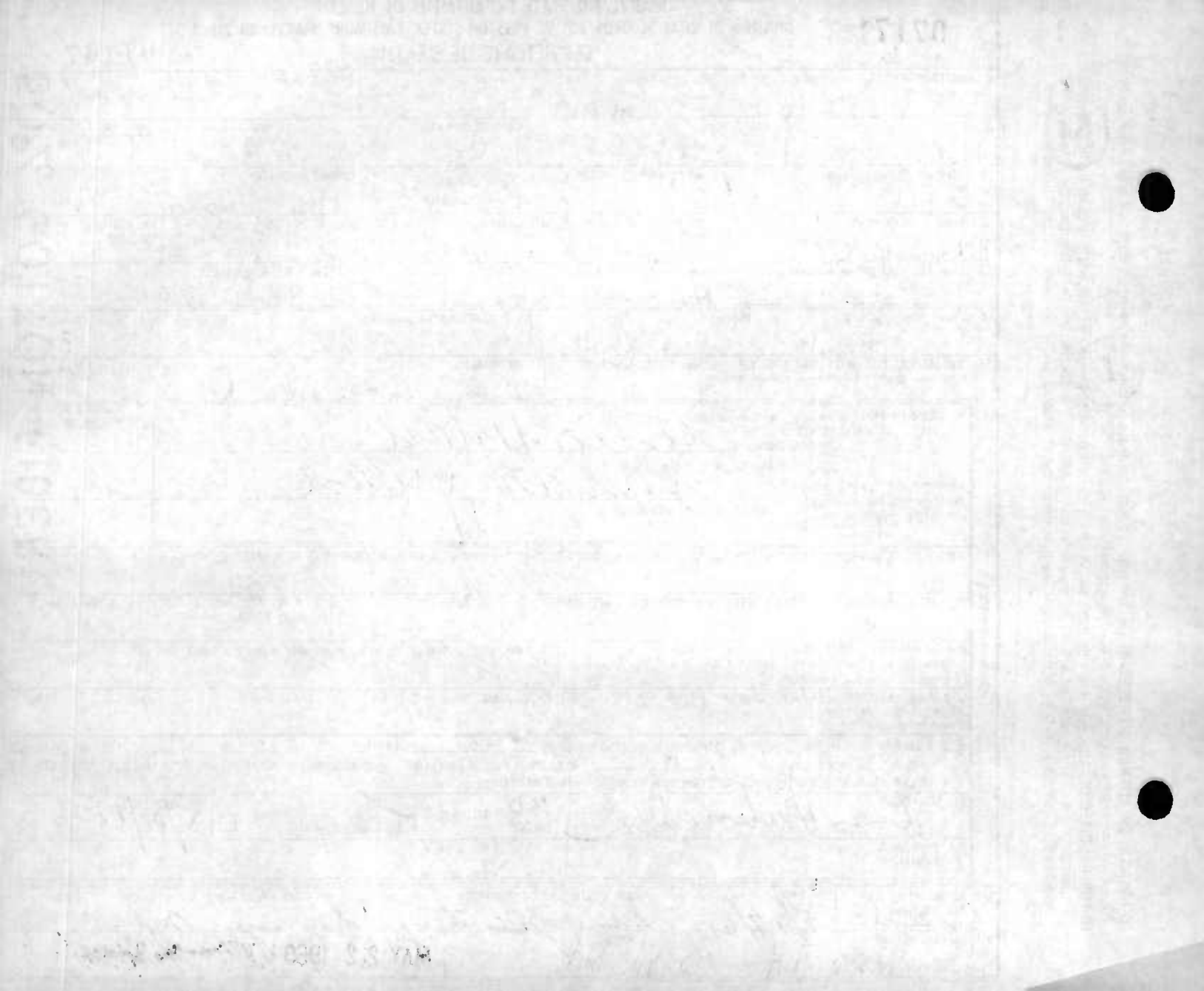
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07167

1. DECEASED-NAME (Type or print) First: <u>Wilbur</u> Middle: <u>OWEN</u> Last: <u>Nichols</u>			2a. DATE OF DEATH Month <u>5</u> Day <u>14</u> Year <u>1969</u>		2b. HOUR <u>10:05</u> P. M.
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>7-29-1897</u>		6. AGE (In years last birthday) <u>71</u> YRS.	IF UNDER 1 YEAR MONTHS OAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <u>Md</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S. of America</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.	
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington San &amp; Hospital</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Railroad - retired</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Md</u>	13b. COUNTY <u>Howard</u>	13c. CITY OR TOWN <u>Fulton</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>Route 216</u>	
14. FATHER'S NAME First: <u>Frank</u> Middle: Middle Last: <u>Nichols</u>		15. MOTHER'S MAIDEN NAME First: <u>Annie</u> Middle: Middle Last: <u>?</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates at service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address: <u>Washington San &amp; Hospital Records</u> <u>Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7824</u> <u>Coronary artery</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-5</u> , 1969, to <u>5-14</u> , 1969, that (I) (we) last saw the deceased alive on <u>May 14</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. M. L. Nichols</u> M.D.		22c. DATE SIGNED <u>5/14/69</u>		22d. PHYSICIAN'S NAME (Type) <u>Dr. M. L. Nichols</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5/17/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>San Jacinto Cemetery</u>	
24. FUNERAL DIRECTOR <u>Donald J. H.</u>		25a. REC'D BY REGISTRAR <u>May 22 1969</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

Item 18 Film 413 6-5-69 MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
07172					07168					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH					2b. HOUR
First Middle Last Linwood Vernon Nicholson					Month Day Year May 23 1969					P 7:50 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
Male		White		Sept. 7, 1913		55 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		U.S.A.				Montgomery				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Olney		Montgomery General Hosp.		owner/manager		Service Sta.				
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
Maryland		Carroll		Woodbine		Route 1				
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Harry Nicholson			Beulah King							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address	
yes WW 2			213-01-6796			Montgomery General Hospital, Olney, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>										9 mos.
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <u>Site of origin unknown.</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 8, 1969</u> , to <u>May 23, 1969</u> , that (I) (we) last saw the deceased alive on <u>5-23-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Frederick Mooman, M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5-23-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Frederick Mooman, M. D.</u>					22e. ADDRESS <u>Sandy Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		5/26/1969		Morgan Chapel		Carroll, Md.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
C. M. Waltz, Box 241, Sykesville, Md.					MAY 27 1969					

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4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

*James R. Coleman M.D.*  
*B. Rupp M.D.*  
*Charles E. Pumphrey, Inc.*

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last					2a. DATE OF DEATH Month Day Year			2b. HOUR a	
Helen Louise O'Connor					5 17 69			1:19	
3. SEX female		4. RACE Caucasian		5. DATE OF BIRTH 8/2/91		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Wash D C		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Sil. Spg.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Sil. Spg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2104 Belvedere Blvd.	
14. FATHER'S NAME First Middle Last Augustus unknown Thornett					15. MOTHER'S MAIDEN NAME First Middle Last unknown Mary Sweet				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 220-44-8429		17. INFORMANT Address Robert F. O'Connor 3302 Dunnington Rd. Beltsville Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>A.S.H.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4109</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min. year.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 1967, to <u>Apr</u> , 1969, that (I) (we) lost saw the deceased alive on <u>Apr. 15</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>James R. Coleman M.D.</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>May 17, 1969</u>			
22d. PHYSICIAN'S NAME (Type) JAMES R. COLEMAN		22e. ADDRESS 9241 COLUMBIA BLVD SILVER SPRING Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 20, 1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.			
24. FUNERAL DIRECTOR Warren E. Pumphrey, Inc. Silver Spring, Md.				25a. REC'D BY REGISTRAR MAY 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

05133

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pink and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

07174				MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07170					
1. DECEASED-NAME (Type or print) <b>LAWRENCE ADOLPH ORTQUIST</b>						2a. DATE OF DEATH Month <b>5</b> Day <b>31</b> Year <b>69</b>				2b. HOUR <b>2:00 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2-2-07</b>		6. AGE (In years last birthday) <b>62 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>MICHIGAN</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b>				Md.			
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON + SAN. + HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CABINET-MAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>WHEATON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>12031 BLUHILL RD</b>					
14. FATHER'S NAME First Middle Last <b>AMIL ORTQUIST</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>EVA LUNDSTROM</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>368-01-1414</b>		17. INFORMANT <b>Marion Miller</b>		Address <b>Wash. San Hospital</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>403X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nephrosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
19a. DATE OF OPERATION <b>May 28, 69</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Renal Biopsy</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <b>April 23, 1969</b> to <b>May 31, 1969</b> that (I) (we) lost the deceased alive on <b>May 31</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Henry M. Wise, Jr.</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2 June 69</b>							
22d. PHYSICIAN'S NAME (Type) <b>HENRY M. WISE, JR.</b>		22e. ADDRESS <b>1111 SPRING ST. SILVER SPRING, MD.</b>											
23. BURIAL, CREMATION, REMOVAL (Specify) <b>6-4-69</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN</b>		23d. LOCATION (City or Town) (County) (State) <b>ROCKVILLE, MD.</b>							
24. FUNERAL DIRECTOR <b>Wm Chambers Co</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JUN 9 1969</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Miller</b>							

05113

(M)

BOOK COLLECTION

1911



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) First Middle Last <b>LAWRENCE BRUCE OSTERMAN</b>						2a. DATE KNOWN OF DEATH Month Day Year <b>5 12 19 69</b>			2b. HOUR M <b>5:55 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>11/28/1964</b>		6. AGE (In years last birthday) <b>4</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>4</b>		IF UNDER 24 HRS. HOURS MIN. <b>55</b>		
7a. BIRTHPLACE (State or foreign country) <b>Wash., DC</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hosp.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sil. Sp.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1607 Peacock Lane</b>		
14. FATHER'S NAME First Middle Last <b>Leonard Osterman</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Eva Horovitz</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. <b>111-11-1111</b>		17. INFORMANT ADDRESS <b>Leonard Osterman 1607 Peacock Lane</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation due to</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>9100</b> (b) <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>9100</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>5-12-1969</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Deceased child fell into pool and drowned</b>								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>13310 Collingwood Terr. S.S. Montg Md</b>								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>MAY 12, 1969</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 13, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Memorial Garden</b>				23d. LOCATION (City or Town) (County) (State) <b>Falls Church, Va.</b>				
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b> 3501 14th St., N.W., Washington, D.C.						25a. REC'D BY REGISTRAR DATE <b>MAY 15 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Richard Judge</b>				

Blank ledger page with horizontal ruling lines and a vertical margin line on the right. Faint, illegible text is visible through the paper, likely from the reverse side. Two punch holes are present on the right edge.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-1. 5 may be retained for your files.

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## Maryland State Department of Health DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07176 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07172

1. DECEASED-NAME (Type or Print) <i>Raymond Duppy Ottey</i>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <i>5-20 1969</i>			2b. HOUR <i>5:45 P.M.</i>		
3. SEX <i>M.</i>	4. RACE <i>W.</i>	5. DATE OF BIRTH <i>2/17/1930</i>	6. AGE (In years lost birthday) <i>39</i> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <i>May</i> Day <i>20</i> Year <i>1969</i>		
7a. BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Rockville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>12081 Twinbrook Pky</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Plasterer</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>12081 Twinbrook Pky</i>
14. FATHER'S NAME <i>William Ottey</i>			15. MOTHER'S MAIDEN NAME <i>Glema Maddy</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>579-36-1674</i>		17. INFORMANT <i>Kaye M. Ottey (Above address)</i>			ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PLANNED Barbiturate poisoning</i> <i>9500</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Overdose of barbiturates</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>14 hr.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <i>4:30 P.M. 5/20 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Took overdose of barbiturates</i>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>12081 Twinbrook Pky. Rockville Montg. Md.</i>				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Bell</i>			M.D.			22b. DATE SIGNED <i>May 21, 1969</i>		
EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5/23/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Co lmar Manor, Md.</i>		
24. FUNERAL DIRECTOR <i>Nalley's Funeral Home</i>				ADDRESS <i>Mt. Rainier, Maryland</i>		25a. REC'D BY REGISTRAR <i>MAY 26 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

7002 801  
300 4000



MAY 26 1952

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07177

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07173

1. DECEASED-NAME (Type or Print) <i>George David Overholtzer</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>5</i> Day <i>11</i> Year <i>1969</i>			2b. HOUR <i>4:35</i> P.M.			
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Oct. 8, 1915</i>	6. AGE (In years last birthday) <i>53</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>5</i> Day <i>11</i> Year <i>1969</i>			
7a. BIRTHPLACE (State or foreign country) <i>PA.</i>		7b. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Mont. Kensington</i>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>11209 Sandy Ct.</i>	
14. FATHER'S NAME <i>MeLvin Overholtzer</i>			15. MOTHER'S MAIDEN NAME <i>Mary Recklee</i>			ADDRESS <i>Silver Springs Md.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>Yes 1944-1945</i>			16b. SOCIAL SECURITY NO. <i>214-16-7225</i>		17. INFORMANT <i>Mrs. George Overholtzer</i>			ADDRESS <i>11704 Idlwood Rd.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure Pulmonary Edema</i> <i>485X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Broncho Pneumonia Confluent</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4 days</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2h.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic Alcoholism</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>May 12, 1969</i>			
EXAMINER'S NAME (Type) <i>John G. Ball</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 14, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. View Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Emmitsburg, Frederick Co. Md.</i>			
24. FUNERAL DIRECTOR <i>Clarence E. Wilson</i>				ADDRESS <i>Emmitsburg, Md.</i>		25a. REC'D BY REGISTRAR <i>May 15 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Clarence E. Wilson</i>	



07117

HOW TARE  
CASH DIS

RECEIVED FROM THE MEDICAL DEPARTMENT  
HOSPITAL ESTABLISHED IN 1848



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07178

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07174

1. DECEASED-NAME (Type or Print) <b>JERRY HUGH PAGE</b>			First Middle Lost			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>5-22-1969</b>			2b. HOUR <b>8:50</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7-5-60</b>		6. AGE (In years last birthday) <b>8</b> YRS. <b>10</b> MONTHS <b>17</b> DAYS		IF UNDER 1 YEAR HOURS MIN.		IF UNDER 24 HRS.		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b>			
10. CITY OR TOWN OF DEATH <b>Takoma Park, Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. San. &amp; Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>P.G.</b>			13c. CITY OR TOWN <b>S.S.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET AND NUMBER <b>100-C Ames Road</b>			14. FATHER'S NAME <b>Francis Page</b>			15. MOTHER'S MAIDEN NAME <b>Lucille Cunningham</b>			First Middle Lost			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Mother</b>			ADDRESS <b>100-Ames Rd, Silver Spring, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple extreme injuries with</b> <b>8147</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>exsanguination incurred when struck</b> DUE TO, OR AS A CONSEQUENCE OF <b>by auto</b> (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>8</b> HOUR <b>PM</b> <b>5-22 19 69</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Deceased, crossing highway, was struck by auto</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Street -- New Hamp Ave</b>				21f. LOCATION Street or R.F.D. No. City or Town County <b>Southampton Dr. Silver Spring Md. Montg State</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Belden R. Reap</b>				EXAMINER'S NAME (Type) <b>Belden R. Reap, MD</b>				22b. DATE SIGNED <b>MAY 22, 1969</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE <b>5-26-69</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>				
23d. LOCATION (City or Town) (County) (State) <b>Montgomery County</b>				24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>				25a. REC'D BY REGISTRAR <b>JUN 2 1969</b>				
25b. REGISTRAR'S SIGNATURE <b>William Judge</b>												

05174

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, and any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07175			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOUR		
HANS			PETER		PAIKERT				5 20 1969		5 15 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year	
MALE		W.		11-11-1899		69 YRS						5 30 1969	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
GERMANY			NATURALIZED						MONTGOMERY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
ROCKVILLE			SUBURBAN 5630 FISHERS LANE			ENGINEER			RESEARCH DEVELOPMENT				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER	
MARYLAND			BALTO			BALTIMORE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2308 POPLAR DRIVE	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
UNKNOWN			UNKNOWN										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO			186-10-7854			Richard M. Elworthy			2308 Poplar Drive			21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion Acute -</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arterio Sclerosis -</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		years	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
ACTUAL SIGNATURE			John E. Ball			M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			May 21, 1969	
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			May 23, 1969		Meadow Ridge Cemetery			Howard Md.					
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Loring Byers Chapel						8728 Liberty Road		21133		DATE MAY 23 1969		Charles Judge	

STATE OF  
NEW YORK

03130

WORK OF JARVIS'S OFFICE IN DEPT.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
07180					07176					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH					
First Middle Last					Month Day Year					
HARRY PETER PAELOGOGOS					5 20 1969					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		2b. HOUR		
MALE		WHITE		2-23-92		79 YRS.		9:35 P.M.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
GURNEY EUROPE		AMERICAN				MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
TAKOMA PARK			WASHINGTON SAN. & HOSP.			BARBER				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			MONTGOMERY		S.S.				18 INDIAN SPRING DR.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
PETER PAELOGOGOS			MARIA BARBIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address				
NO			579-18-4742			HOSPITAL RECORD, TAKOMA PARK, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE HOOKS.										
4123 DUE TO, OR AS A CONSEQUENCE OF										
(b) BRONCHO PNEUMONIA DAYS.										
DUE TO, OR AS A CONSEQUENCE OF										
(c) ARTERIOSCLEROTIC HEART DISEASE YRS.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
CEREBRAL ARTERIOSCLEROSIS ADVANCED										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>SPRING, 1966</u> , to <u>MAY 20, 1969</u> , that (I) (we) lost saw the deceased alive on <u>MAY 20, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					22c. DATE SIGNED					
ALBERT H. GROLLMAN MD.					5/21/69					
22d. PHYSICIAN'S NAME (Type or print)					22e. ADDRESS					
ALBERT H. GROLLMAN					1106 SPRING ST., SILVER SPRING					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		23 MAY 1969		GLENWOOD CEMETERY		WASHINGTON DC.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
RINALDI FUNERAL HOME, INC., 4016A AVE. NW, #20012					MAY 23 1969		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers of pages 4 and 5 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07181

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07177

1. DECEASED-NAME (Type or print) First Middle Last Raymond Clay Parker			2a. DATE OF DEATH 5 Month 21 Day 69Year		2b. HOUR 10A.M.
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH March ?, 1893	
6. AGE (In years lost birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Jefferson, Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) University Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Janitor	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4719 Foote St., N.E.			
14. FATHER'S NAME First Middle Last Sandy Parker			15. MOTHER'S MAIDEN NAME First Middle Last Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 197-07-6798		17. INFORMANT Address William P. Parker 4719 Foote St NE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Murmured Infection</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Murdered Insufficient</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heart Murmured Insufficient</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 6 weeks 5 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Grandchild Arteriosclerosis, Arteriosclerosis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 5/1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Edmond C. Maniquez</u>		22c. DATE SIGNED 5/21/69		22d. PHYSICIAN'S NAME (Type) Edmond C. Maniquez	
22e. ADDRESS 1801 9th St N.W. Wash DC					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-24-69		23c. NAME OF CEMETERY OR CREMATORY Harmony	
23d. LOCATION (City or Town) (County) (State) Highland Park Md					
24. FUNERAL DIRECTOR H. B. Vah... 41925 Dune Rd NE		24a. REC'D BY REGISTRAR DATE MAY 26 1969		24b. REGISTRAR'S SIGNATURE Richard J. Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07182				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07178				
Items#23a, thru, d & 24, Film G413 6/17/69				CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P			
Sammie			(none)	Parker, Jr.			May 10 1969			10:35 M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		Negro		30 January 1938			31 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
North Carolina		USA					Montgomery Md.					
1d. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			The Clinical Center, NIH			Driver Messenger						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Washington, D.C.						Washington				5011 12th Street, N.E.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Sammie			Parker, Sr.			Vila			Parker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT						
No			245-54-6345			The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Intracerebral hemorrhage											3 days	
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) Chronic myelogenous leukemia											1 year	
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from 8 May 1969, to 10 May 1969, that (X) (we) last saw the deceased alive on 10 May 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did (not) view the body after death.												
22b. SIGNATURE						DEGREE			22c. DATE SIGNED			
Peter G. Burk						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			11 May 1969			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
Peter G. Burk, M.D.						The Clinical Center, National Institutes of Health, Bethesda, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			May 15, 69			Mt. Calvary Church Cem.			Bahama Durham N.C.			
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Jones & Sons, Ellis O., 415 Dowd St., Durham, N.C.									DATE MAY 15 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07183

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07179

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Miller		Vernon	PARSONS		May 11 1969		1130 M		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male	Caucasian		Nov. 14, 1882		86 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Ohio		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Naval Hospital		U.S. Marine Corps		N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Bethesda				4706 Glenbrook Parkway	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
James		Parsons			Mary				Miller
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes				Bethesda, Md.		Mrs. Naomi Parsons, 4706 Glenbrook Parkway			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>4123 Congestive heart failure</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Coronary artery disease</u>								years	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from <u>March 14</u> , 19 <u>69</u> , to <u>May 11</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>May 11</u> , 19 <u>69</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>E. M. Jewusiak</u>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		E. M. JEWUSIAK, M. D..		22e. ADDRESS		May 12, 1969			
				Naval Hospital, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5-15-69		Arlington National		Arlington Va.			
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
7557 Wisconsin Ave., Bethesda, Md.				MAY 15 1969		<u>William J. Judge</u>			

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

07184

07180

1. DECEASED-NAME (Type or print) <b>Herba Baker</b>			First Middle Last <b>Patterson</b>			2a. DATE OF DEATH Month Day Year <b>May 2 1969</b>			2b. HOUR AM PM <b>6:12 AM</b>					
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>26 September 1897</b>			6. AGE (In years last birthday) <b>71</b> YRS.					
7a. BIRTHPLACE (State or foreign country) <b>Alabama</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Alabama</b>			13b. COUNTY <b>Tuscaloosa</b>			13c. CITY OR TOWN <b>Tuscaloosa</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13e. STREET AND NUMBER <b>1311 12th Avenue</b>			14. FATHER'S NAME First Middle Last <b>Herbert H. Baker</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mahulda Spradling</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>579-60-5456</b>			17. INFORMANT <b>Bethesda, Maryland</b> Address <b>The Medical Records, The Clinical Center,</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Gram-negative sepsis</b> 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchopneumonia, bilateral</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>? metastatic breast ca., right adrenal gland &amp;</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Acute Granulocytic Leukemia</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>					
									days					
									months					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>23 February, 1969</b> , to <b>2 May</b> , 19 <b>69</b> , that <b>he</b> (we) last saw the deceased alive on <b>2 May</b> , 19 <b>69</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>he</b> (we) (did) (do not) view the body after death.									22b. SIGNATURE <b>Dr. Riddick, MD</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>2 May 1969</b>		
22d. PHYSICIAN'S NAME (Type) <b>David H. Riddick, MD.</b>			22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			23b. DATE <b>5-3-1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Birmingham, Alabama</b>					
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SON, INC.</b> ADDRESS <b>5130 WISC. AVE., N. W. WASH., D. C. 20016</b>						25a. REC'D BY REGISTRAR <b>MAY 8 1969</b>			25b. REGISTRAR'S SIGNATURE <b>V. C. ...</b>					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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John Baker

Female

White

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Male

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The Clinical Center, National

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The Clinical Center, National  
Institution of Health, Baltimore, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07185										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07181									
1. DECEASED-NAME (Type or print) First Middle Last Winfield S Pealer										2a. DATE OF DEATH Month Day Year May 29 1969										2b. HOUR 6:05 PM									
3. SEX M			4. RACE W			5. DATE OF BIRTH Nov. 8 1886					6. AGE (In years last birthday) 88 YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.													
7a. BIRTHPLACE (State or foreign country) Ohio			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Montgomery Md.																		
10. CITY OR TOWN OF DEATH Silver Spring					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LAWYER					12b. KIND OF BUSINESS OR INDUSTRY LAW														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md.					13b. COUNTY Montgomery					13c. CITY OR TOWN Silver Spring					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 3362 Glenview Dr.									
14. FATHER'S NAME First Middle Last Peter C Pealer					15. MOTHER'S MAIDEN NAME First Middle Last Katherine Caines					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) Yes WWI										16b. SOCIAL SECURITY NO. 297-32-4977					17. INFORMANT Mayme Pealer: 3362 Glenview Dr S.E.S.P.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of colon</u> 1538 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 5/28, 1969, to 5/29, 1969, that (I) (we) last saw the deceased alive on 5/29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Myron G. Jenkins MD										22c. DATE SIGNED 5/29/69									
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS 2309 Shorefield Rd Wheaton Md																								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 6-3-69					23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl. Cem.					23d. LOCATION (City or Town) (County) (State) Baltimore Md.														
24. FUNERAL DIRECTOR W.W. Chambers Co.					ADDRESS 8655 Kensington St. Sp					25a. REC'D BY REGISTRAR JUN 4 1969					25b. REGISTRAR'S SIGNATURE Charles J. Jones														

07182

07

EXHIBIT IN DEATH

STATE OF TEXAS, COUNTY OF DALLAS, DECEMBER 1911



Witness my hand and seal this 1st day of December, 1911.



Notary Public in and for the State of Texas

My commission expires the 1st day of December, 1912.

Notary Public

07186

## CERTIFICATE OF DEATH

07182

1. DECEASED-NAME (Type or print) <b>Curtis Blake Peer</b>			2a. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>1969</b>			2b. HOUR P <b>9:45 M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>16 September 1941</b>		6. AGE (In years last birthday) <b>27</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Virginia</b>		13b. COUNTY <b>Fairfax</b>		13c. CITY OR TOWN <b>Falls Church</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>1915 Hileman Road</b>		14. FATHER'S NAME First Middle Last <b>Jetson R. Peer</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Pearl Foltz</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>233-66-5371</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, NIH, Bethesda, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Massive gastrointestinal hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Intravascular coagulation</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>12 hours</b> <b>24 hours</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Acute Myelogenous Leukemia 8 weeks</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8 April</b> , <b>1969</b> , to <b>14 May</b> , <b>1969</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>14 May</b> , <b>1969</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>David H. Riddick MD</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>14 May 1969</b>	
22d. PHYSICIAN'S NAME (Type) <b>David H. Riddick, M.D.</b>				22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 17, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shenandoah Mem. Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Winchester, Frederick, Va.</b>	
24. FUNERAL DIRECTOR <b>Harold M. Baggett</b>				25a. REC'D BY REGISTRAR <b>May 19 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> <span>07187</span> <span>CERTIFICATE OF DEATH</span> <span>7183</span> </div>									
1. DECEASED-NAME (Type or print) <i>Ethel</i>			First <i>P.</i> Middle <i>P.</i> Last <i>Persons</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>24</i> Year <i>1969</i>			2b. HOUR <i>1:03 P</i>
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>9/22/85</i>		6. AGE (In years last birthday) <i>83</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Corning New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Silver Spring Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Colonialville Nurs H</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Reg. Nurse</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1001-Houston Ave.</i>	
14. FATHER'S NAME <i>Russell</i>			First <i></i> Middle <i></i> Last <i>Pierce</i>			15. MOTHER'S MAIDEN NAME <i>Jennie</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) <i>NU</i>		16b. SOCIAL SECURITY NO. <i>266-36-8220</i>		17. INFORMANT <i>MRS. MARY JANE PETTIT, 1001 HOUSTON AVE</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic bronchitis and emphysema</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Tracheostomy for 40 years</i>									<i>1 week</i> <i>20-30 yrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic heart disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i> P.M. <i></i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i>				
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> , 19 <i>68</i> , to <i>MAY 20</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>MAY 14</i> , 19 <i></i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Bernice A. Bandlau M.D.</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/21/1969</i>		
22d. PHYSICIAN'S NAME (Type) <i></i>					22e. ADDRESS <i>10820 GEORGIA AVE WHITEHALL, MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 23, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		23d. LOCATION (City or Town) (County) (State) <i>Arlington</i> <i></i> <i>Virginia</i>			
24. FUNERAL DIRECTOR <i>Takoma Funeral Home Inc. J.A. Walters, 254 Cornell St NW</i>					25a. REC'D BY REGISTRAR <i></i>		25b. REGISTRAR'S SIGNATURE <i></i>		
					DATE <i>MAY 23 1969</i>				

03183

RECEIVED DECEMBER 1951

U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

MAY 23 1952

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07188

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07184

Item 6 Film 12 5/9/69 kk

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
IRIS		L.		PFEIFFER	5 - 1 - 69		12:30 AM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE	WHITE		4-23-23		45 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Ohio	USA				Montgomery County, Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring, Md.	Holy Cross		Secretary, US Govt		N.Y. H.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.	Montgomery		Silver Spring				13416 TAMARACK RD.	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
red M.			Schaber	Mabel Alice				Landrum
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		
no				yes		Silver Spring, Md. John Leo Pfeiffer (husband) 13416 Tamarack Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1830</u> <u>in anition</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of ovary</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>18 mo.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few wks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town
						County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>68</u> , to <u>5/1</u> , 19 <u>69</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>5/1</u> 19 <u>69</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.								
22b. SIGNATURE <u>G. Lennard Gold</u>					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>5/2/69</u>
22d. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold</u>					22e. ADDRESS <u>9801-Ga. Ave. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
<u>Burial</u>		<u>May 5, 1969</u>		<u>Gate of Heaven Cemetery</u>		<u>Silver Spring, Maryland</u>		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>					25a. REC'D BY REGISTRAR <u>MAY 7 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07189

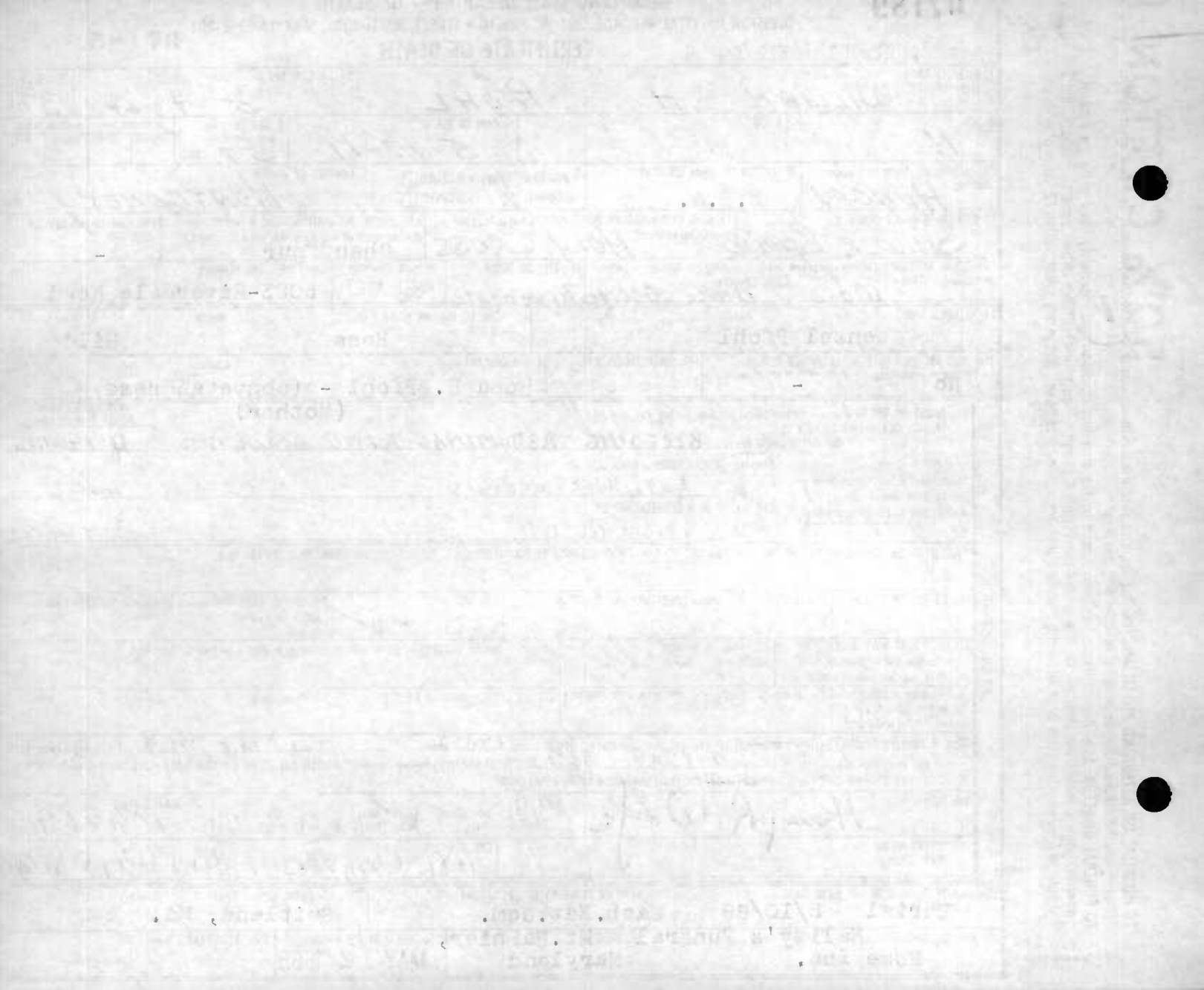
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07185

Item #8, Film G413 6/12/69 km

1. DECEASED-NAME (Type or print) <b>WILLIAM H. PFOHL</b>			2a. DATE OF DEATH Month <b>5</b> Day <b>7</b> Year <b>69</b>			2b. HOUR <b>3:47 PM</b>	
3. SEX <b>M.</b>		4. RACE <b>W.</b>		5. DATE OF BIRTH <b>5-17-11</b>		6. AGE (In years last birthday) <b>57</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>HUNGARY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOLY CROSS</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Chauffeur</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Riverdale</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>Wenzel</b> Middle <b>Pfohl</b>		15. MOTHER'S MAIDEN NAME First <b>Rosa</b> Middle <b>Hild</b>		13e. STREET AND NUMBER <b>5023-Riverdale Road</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Rosa H. Pfohl - (above address)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BLEEDING ABDOMINAL AORTIC ANEURYSM</b> <b>441.2</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>INFECTION</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 MONTHS</b> <b>YEARS</b> <b>3-4 WEEKS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1952</b> , 19, to <b>1969</b> , that (I) (we) last saw the deceased alive on <b>7 MAY 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Harry R. Wolfe</b>		22c. DATE SIGNED <b>7 MAY 69</b>		22d. PHYSICIAN'S NAME (Type) <b>1131 UNIVERSITY BLVD W., S.S. MD</b>			
23a. BURIAL CREMATION, REMOVAL, ETC. <b>Burial</b>		23b. DATE <b>5/10/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wash. Nat. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		ADDRESS <b>Mt. Rainier, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 12 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





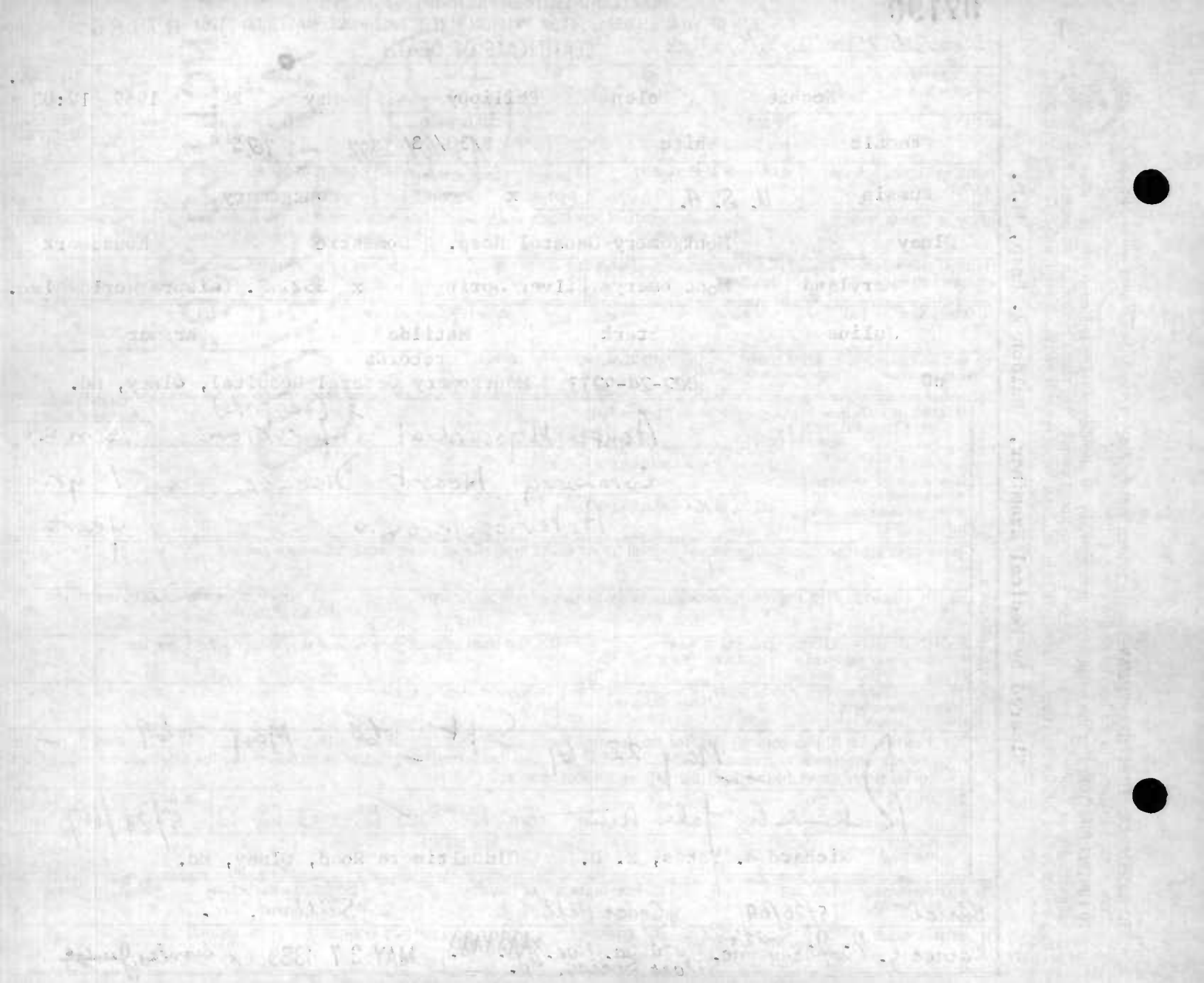
4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Medical Examiner, Beldon R. Peap, M.D.

07190 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07186 Items 5&6 Film G413 6/6/69 kk <b>CERTIFICATE OF DEATH</b>											
1. DECEASED-NAME (Type or print) First Middle Last <b>Sophie Helen Philippy</b>						2a. DATE OF DEATH Month Day Year <b>May 24 1969</b>			2b. HOUR <b>12:03 M</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>8/30/94 1892</b>		6. AGE (In years last birthday) <b>167</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.					
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Montgomery General Hosp. Domestic</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housework</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3521 S. Leisure World Blvd.</b>			
14. FATHER'S NAME First Middle Last <b>Julius Stark</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Matilda Kramer</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown (If yes give war or dates of service) <b>no</b>		16b. SOCIAL SECURITY NO. <b>002-24-9233</b>		17. INFORMANT <b>records</b> Address <b>Montgomery General Hospital, Olney, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction (second)</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) <b>Coronary Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>1 yr.</b> <b>years.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1968</b> , to <b>May 1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>May 22 1969</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.											
22b. SIGNATURE <b>Richard A. Yates</b>				DEGREE <b>M. D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5/24/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Richard A. Yates, M. D.</b>				22e. ADDRESS <b>Old Baltimore Road, Olney, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/26/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Switland, Md.</b>					
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey Inc.</b>						ADDRESS <b>8434 Ga. Ave. Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 27 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07191

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Terrey Wilson Phillips</u>			2a. DATE OF DEATH 5 Month <u>15</u> Day <u>69</u> Year		2b. HOUR <u>2:15</u> M
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>6-2-92</u>		6. AGE (In years last birthday) <u>76</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTH PLACE (State or foreign country) <u>New York</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.	
10. CITY OR TOWN OF DEATH <u>Bethesda</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Attorney</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>LAW</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>	13b. COUNTY <u>Mont.</u>	13c. CITY OR TOWN <u>Bethesda</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>3963 Rosemary St.</u>	
14. FATHER'S NAME First Middle Last <u>WILSON E. PHILLIPS</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>KATIE - BAIRD</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>Yes</u> (If yes give year or dates of service) <u>U.S.A.</u>		16b. SOCIAL SECURITY NO.		17. INFORMANT <u>Wife - Betty Phillips - Same As #13</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>575X METABOLIC ALKALOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary edema and congestion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gastric hemorrhage, diffuse</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ARTERIO SCLEROTIC HEART DISEASE, OLD MYOCARDIAL INFARCTION, CHOLECYSTECTOMY</u>					
19a. DATE OF OPERATION <u>5-13-69</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>subacute cholecystitis</u>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-12</u> , 19 <u>69</u> , to <u>5-15</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>5-15-69</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John O Robben M.D.</u>				22c. DATE SIGNED <u>5-15-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>John O. Robben M.D.</u>				22e. ADDRESS <u>10400 CONNETT AVE KENSINGTON MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE <u>5/19/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>	
23d. LOCATION (City or Town) <u>SUITLAND</u>		(County) <u>MD.</u>		(State)	
24. FUNERAL DIRECTOR <u>JOSEPH GAWLER'S SONS, 5130 WISCONSIN AVE. WASHINGTON, D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 21 1969</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

07191



RECEIVED

NOV 10 1964

U.S. DEPT. OF JUSTICE

NOV 10 1964

RECEIVED

NOV 10 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07192

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07188

1. DECEASED-NAME (Type or print) <b>Jessie</b> First <b>MAY</b> Middle <b>Pierce</b> Last			2a. DATE OF DEATH <b>May</b> Month <b>4</b> Day <b>1969</b> Year <b>22</b> Hour <b>2</b> Min <b>25</b>	
3. SEX <b>Female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>1-18-17</b>		6. AGE (In years last birthday) <b>52</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>America</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Sanitarium</b>		9. COUNTY OF DEATH <b>Montgomery</b> Md.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>
13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12b. KIND OF BUSINESS OR INDUSTRY
14. FATHER'S NAME First <b>N.D.</b> Middle <b>Baron</b> Last		15. MOTHER'S MAIDEN NAME First <b>Ida</b> Middle <b>Miller</b> Last		13e. STREET AND NUMBER <b>910 South Belgrade Road</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>225-18-5777</b>		17. INFORMANT <b>Patient's chart</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>5718</b> IMMEDIATE CAUSE (a) <b>HEMORRHAGING ESOPHAGEAL VARICES</b> DAYS DUE TO, OR AS A CONSEQUENCE OF (b) <b>INTERPORTAL CIRRHOSIS OF THE LIVER</b> YEARS DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <b>4-26</b> , 19 <b>69</b> , to <b>5-4</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>5-3</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Abraham W. Danisat</b>		22c. DATE SIGNED <b>5-4-69</b>		22d. PHYSICIAN'S NAME (Type) <b>ABRAHAM W. DANISAT</b>
22e. ADDRESS <b>1106 SPRING ST. S.S.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		
23b. DATE <b>5-6-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Bladensburg, Maryland</b>
24. FUNERAL DIRECTOR <b>F. J. Collins 500 Univ. Blvd. W. Sil. Sp. Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 7 1969</b>		25b. REGISTRAR'S SIGNATURE <b>William Judge</b>





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07189					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year		2b. HOUR				
Mary VanVeen Pilson						MAY 25 1969			5 25		2 PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			
Fe-		W.		10/11/32		36 YRS.		MONTHS DAYS		HOURS MIN		Month Day Year			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH							
Washington, DC		USA		WIDOWED		DIVORCED		Montgomery				Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Bethesda			6800 Wisconsin Ave In-town Motel			Housewife			Home						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
md.			Montgomery			Brookmont			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4016-62nd St			
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last						
Eugene Benjamin VanVeen						Louise Larcombe									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
no			577-42-3305			Benjamin F. Pilson			Brookmont, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drug Poisoning										1 1/2 hr.					
9502 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) overdose Librium + Barbituates					
DUE TO, OR AS A CONSEQUENCE OF										(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				2:30 P.M. 5/25 1969				Took overdose Librium + Barbituates							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
				Motel				6800 Wisconsin Bethesda Montgomery Md							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				John G. Ball				M.D.				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				John G. Ball				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				MAY 26, 1969			
								ADDRESS (Street, city, town, or county)				BETHESDA, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Cremation			28 May 69			Cedar Hill Crematory			Suitland Md.						
24. FUNERAL DIRECTOR						ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey						Bethesda, Maryland						JUN 5 1969		[Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Medical Examiner Beldon R. Reap,

MEDICAL CERTIFICATION

07194		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07190	
1. DECEASED-NAME (Type or print) <b>Haywood</b> <b>(NMN)</b> <b>Prather</b>			2a. DATE OF DEATH Month <b>5</b> Day <b>24</b> Year <b>69</b>		2b. HOUR <b>2:00A.M.</b>
3. SEX <b>Male</b>	4. RACE <b>C</b>	5. DATE OF BIRTH <b>6-7-26</b>		6. AGE (In years last birthday) <b>42</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Olney</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Montgomery General</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Janitor</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Sandy Spg.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>Box 187 Sandy Spring, Md.</b>	
14. FATHER'S NAME First <b>Irvin</b> Middle <b>G.</b> Last <b>Prather</b>	15. MOTHER'S MAIDEN NAME First <b>Mamie</b> Middle <b>B.</b> Last <b>Prather</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <b>1944-46</b>	16b. SOCIAL SECURITY NO.	17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4/100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertensive C.V. - Renal Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>1 yr.</b> <b>2 yr.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/13</b> , 19 <b>61</b> , to <b>5/24</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>5/17</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Charles H. Ligon, M.D.</b>	OEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>5/24/69</b>
22d. PHYSICIAN'S NAME (Type) <b>Charles H. Ligon, M.D.</b>	22e. ADDRESS <b>Sandy Spring, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/27/69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Brooke Grove Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Laytonsville, Montg., Md.</b>	
24. FUNERAL DIRECTOR <b>George R. Snowden</b>	ADDRESS <b>Rockville</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR 415-14  
45M - 1-69

07195		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07191	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last <i>James Nelson Prather</i>			2a. DATE OF DEATH Month Day Year <i>May 22 1969</i>			2b. HOUR <i>3:07 PM</i>	
3. SEX <i>male</i>		4. RACE <i>C</i>		5. DATE OF BIRTH <i>5-7-1899</i>		6. AGE (in years last birthday) <i>70</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired-Truck Driver</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Gaithersburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>Howard Prather</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Rosie Lancaster</i>		13e. STREET AND NUMBER <i>Gaithersburg, Md.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-05-4384</i>		17. INFORMANT Address <i>Lancaster</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute pericarditis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>3910</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <i>5/16/69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca &amp; Prostate</i>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/7</i> , 1969, to <i>5/22</i> , 1969, that (I) (we) last saw the deceased alive on <i>5/21</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Richard N. Edenbaum MD</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/23/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>RICHARD H. EDENBAUM</i>				22e. ADDRESS <i>4700 Bradley Boulevard Chevy Chase Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>5-26-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>BROOKE GROVE CEM.</i>		23d. LOCATION (City or Town) (County) (State) <i>LAYTONSVILLE, MONTG. MD</i>	
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i>				ADDRESS <i>ROCKVILLE, MD</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
				DATE <i>MAY 28 1969</i>		25b. REGISTRAR'S SIGNATURE	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-100-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07196

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07192

1. DECEASED-NAME (Type or Print) <b>Kevin Tyrone Pumphrey</b>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>5 30 69</b>			2b. HOUR <b>5:50 AM</b>			
3. SEX <b>M</b>	4. RACE <b>C</b>	5. DATE OF BIRTH <b>2-22-62</b>	6. AGE (In years last birthday) <b>7</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>5</b> Day <b>30</b> Year <b>69</b>			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Montgomery General</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>minor</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sandy Spg.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>18514 Brooke Rd.</b>	
14. FATHER'S NAME First <b>Melvin</b> Middle <b>Pumphrey</b> Last <b>Pumphrey</b>			15. MOTHER'S MAIDEN NAME First <b>Joyce</b> Middle <b>Offord</b> Last <b>Pumphrey</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration + Maceration of Brain &amp; 815.6</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Comp. Fractures of Skull.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Trauma.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>5 days.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <b>5/25/69</b> HOUR <b>12:01 P.M.</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Rode bike in front of car.</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Street.</b>		21f. LOCATION Street or R.F.D. No. <b>Brooke Rd. Near Rt 28</b> City or Town <b>Sandy Spring</b> County <b>Mont.</b> State <b>Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John G. Ball</b> EXAMINER'S NAME (Type) <b>Dr. Perez</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>May 30, 1969</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/3/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Sandy Spring, Montg. Md.</b>		
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b> ADDRESS <b>Rockville, Md.</b>				25a. REC'D BY REGISTRAR <b>JUN 4 1969</b> DATE		25b. REGISTRAR'S SIGNATURE <b>William D. Judge</b>			



4122

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07197

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07193

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First <b>Herman</b>	Middle <b>Carle</b>	Last <b>Ramey</b>	2a. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>1969</b>			2b. HOUR <b>11:30</b> M			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>February 7, 1886</b>		6. AGE (In years last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.						
10. CITY OR TOWN OF DEATH <b>Kensington</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Hall Sanitarium</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Clerk Merchandise</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2600 Queens Chapel Rd.</b>			
14. FATHER'S NAME First <b>Emmett</b> Middle <b>Ramey</b> Last			15. MOTHER'S MAIDEN NAME First <b>Mame</b> Middle <b>Hawkins</b> Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO. <b>579-20-7839</b>		17. INFORMANT Address <b>Sister</b>			17. INFORMANT Address <b>Sister</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4122 Cardio-vascular-renal disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years -</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Senile psychosis</b> <b>?</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>May 22</b> , 19 <b>69</b> , to <b>May 31</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>May 31</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Katharine A. Chapman, M.D.</b> DEGREE 22c. DATE SIGNED <b>June 1, 1969</b>												
22d. PHYSICIAN'S NAME (Type) <b>Katharine A. Chapman</b>						22e. ADDRESS <b>3924 Baltimore St. Kensington, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			23b. DATE <b>6/2/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bloomfield Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Sparta, Ohio</b>				
24. FUNERAL DIRECTOR ADDRESS <b>The S.H.Hines Co. Washington, D. C.</b>						25a. REC'D BY REGISTRAR <b>JUN 4 1969</b>			25b. REGISTRAR'S SIGNATURE <b>John A. ...</b>			

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THE H. H. HINES CO. MANUFACTURERS

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Asbestos, A. Campbell

07198

## CERTIFICATE OF DEATH

07194

1. DECEASED-NAME (Type or print) <u>Burvie Oates Ramsey</u>			2a. DATE OF DEATH Month <u>5</u> Day <u>31</u> Year <u>69</u>			2b. HOUR <u>6:30</u> AM	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>1-28-10</u>		6. AGE (In years last birthday) <u>59</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>N.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.	
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Broker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>md.</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <u>Charles</u> Middle <u>Ramsey</u> Last <u>Sabers</u>		15. MOTHER'S MAIDEN NAME First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Adams</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>yes</u> (If yes give year or dates of service) <u>WW II</u>		16b. SOCIAL SECURITY NO. <u>578-05-1175</u>		17. INFORMANT Address <u>Sil. Spr. Md.</u> <u>Sarah Alice Ramsey, 10124 Greenock Rd.,</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>2000</u> (b) <u>Reticulum cell sarcoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 mos</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few days</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept., 1968</u> to <u>May 31, 1969</u> , that (I) (we) last saw the deceased alive on <u>5/30</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>G. Lennard Gold</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>5/31/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold</u>				22e. ADDRESS <u>9801-Ga. Ave. Silver Spring, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>June 3, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Mont., Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 3 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07199

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07195

1. DECEASED-NAME (Type or print) <i>Albert D. Reading</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>19</i> Year <i>1969</i>			2b. HOUR <i>6:30</i> M					
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>11/2/1944</i>		6. AGE (In years last birthday) <i>24</i> YRS.		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i> MIN <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Plumber (ret.)</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Private</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Pa.</i>		13b. COUNTY <i>Federal</i>		13c. CITY OR TOWN <i>Federal</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>P.O. Box #9</i>			
14. FATHER'S NAME First <i>John</i> Middle <i>Reading</i> Last <i>Reading</i>			15. MOTHER'S MAIDEN NAME First <i>Almeda</i> Middle <i>Ritter</i> Last <i>Ritter</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>yes</i> (If yes give war or dates of service) <i>Army, 1944-1945</i>			16b. SOCIAL SECURITY NO. <i>179-07-4434</i>			17. INFORMANT Name <i>Mrs. George Remington</i> Address <i>7507-1st Ave, Baltimore</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aneurysm, saccular, abdominal aorta, ruptured</i> <i>441.2</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>5/19</i> , 19 <i>69</i> , to <i>5/19</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5/19</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Robert C. Daddar</i>						DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/20/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>ROBERT C. DADDAR, MD</i>						22e. ADDRESS <i>5413 CEDAR LANE, BETHESDA, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>5/23/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hillside</i>			23d. LOCATION (City or Town) (County) (State) <i>Roslyn, Pennsylvania</i>			
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home-1331 Rockville Pike, Rockville, Md.</i>						25a. REC'D BY REGISTRAR <i>MAY 22 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

29170

Rockville, Md. May 22 1962

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a film MARYLAND STATE DEPARTMENT OF HEALTH  
413 6-3-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07200

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07196

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR					
GERALD VINCENT REYNOLDS								MAY 20 1969								09:10 AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		Month		Day		Year		2d. HOUR	
MALE		CAUC		19 SEPT. 1906		62 YRS.						MAY 20 1969								9:10 AM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH														Md.	
NEW YORK		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		MONTGOMERY															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY															
BETHESDA		BETHESDA NAVAL HOSP.		US NAVY																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER													
VIRGINIA				FALLS CHURCH				305 WALNUT ST.													
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last							
JOHN REYNOLDS								Margaret Reilly													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
YES		1940-1960				MISS. SUSAN REYNOLDS		8220 TORY RD.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pending</u> Laennec's cirrhosis of liver with 571.0 DUE TO, OR AS A CONSEQUENCE OF hepatic failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF (c)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture of left femur																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 6 PM 5/16 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fall at home causing fracture of left hip																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State 305 Walnut St. Falls Church Va.																	
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE		John G. Ball		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED May 20, 1969									
EXAMINER'S NAME (Type)		JOHN G. BALL MD.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)															
Burial		May 22, 1969		ARLINGTON NATIONAL CEMETERY		ARLINGTON, ARLINGTON, VA.															
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
ARLINGTON FUNERAL HOME		3901 NORTH FAIRFAX DR. ARLINGTON, VA.		MAY 26 1969		Charles Judge															

05300

MEDICAL EXAMINATION REPORT OF DOCTOR

DATE: MAY 28, 1968

TIME: 10:00 AM

LOCATION: NEW YORK

REASON: HYPERTENSION

SYMPTOMS: NONE

TESTS: BLOOD PRESSURE

RESULTS: 160/90

DIAGNOSIS: HYPERTENSION

TREATMENT: NONE

PROGNOSIS: GOOD

REMARKS: NONE

SIGNATURE: DR. J. J. J.

DATE: MAY 28, 1968

TIME: 10:00 AM

LOCATION: NEW YORK

REASON: HYPERTENSION

SYMPTOMS: NONE

TESTS: BLOOD PRESSURE

RESULTS: 160/90

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07201

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07197

1. DECEASED-NAME (Type or print) <b>Aubrey G. Richmond</b>			2a. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1969</b>			2b. HOUR <b>6:15 A.M.</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>DEC. 1, 1894</b>		6. AGE (in years last birthday) <b>94</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MISS.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.				
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTWOOD N.H.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>REG.-CIVIL SERVANT</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV'T</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>MONTG.</b>		13c. CITY OR TOWN <b>BETHESDA</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4605 HIGH ST.</b>	
14. FATHER'S NAME First Middle Last <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>26-46-0214</b>		17. INFORMANT Address <b>FORREST GRIMES-4721 ALTON PL, N.W. WASH., D.C.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis myocardial ischemia.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr.</b> <b>1 hr.</b> <b>2 yrs.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , to <b>5/3</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>5/2</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>S.A. Thomas MD</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5/3/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>S.A. Thomas MD.</b>				22e. ADDRESS <b>4301 48th St N.W. Wash. DC.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>5/6/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>BLADENSBURG, MD.</b>				
24. FUNERAL DIRECTOR <b>JOS. GAWLER'S SONS</b>				ADDRESS <b>5130 WIS. AVE. N.W. WASHINGTON, D.C.</b>		25a. REC'D BY REGISTRAR <b>MAY 8 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



10570



1621  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07202

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07198

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <i>Dorothy S. Ricketts</i>			2a. DATE OF DEATH Month Day Year <i>May 29 1969</i>			2b. HOUR M <i>7:15</i>						
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>4/11/12</i>		6. AGE (In years last birthday) <i>57</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.						
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Supervisor</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>govt.</i>				12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Derwood</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>15801 - Redland Rd.</i>				
14. FATHER'S NAME First Middle Last <i>Alfred Ritter</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Gertrude Hoge</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>			16b. SOCIAL SECURITY NO. <i>no</i>			17. INFORMANT <i>Francis Ricketts</i> Address <i>3301 R. 26 Ave.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. WHAT WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchio genesis &amp; O lung &amp;</i> <i>1621</i> DUE TO, OR AS A CONSEQUENCE OF <i>gen. metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION <i>1-14-69</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Expt. Thrombolytic &amp; Cerebral infarct</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSISTENT IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>1-14</i> , 19 <i>69</i> , to <i>5-24</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5-24</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>V.C. DeGuzman</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>May 29, 1969</i>				
22d. PHYSICIAN'S NAME (Type) <i>V.C. DEGUZMAN</i>						22e. ADDRESS <i>1234 19 NW WASH DC</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>6/2/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lukes Church Cem.</i>			23d. LOCATION (City or Town) (County) (State) <i>Derwood Montg. Md.</i>				
24. FUNERAL DIRECTOR <i>1331 Rockville Pike</i>						25a. REC'D BY REGISTRAR <i>JUN 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
TYSON WHEELER FUNERAL HOME Rockville, Md.												



07199

## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First Edwina		Middle B.	Last Ricketts	2a. DATE OF DEATH		Month May		Day 6		Year 1969		2b. HOUR 7:30			
3. SEX female		4. RACE white		5. DATE OF BIRTH 9/22/02		6. AGE (In years last birthday)		66		YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Montgomery		Md.							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		none		12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		5400 - Rock Hill Rd							
14. FATHER'S NAME		First John		Middle Edgar	Last Benson	15. MOTHER'S MAIDEN NAME		First Jessie		Middle Lowell	Last Benson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		509 Dr. Ronald Ricketts		9608 Rock Hill Rd							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, intracerebral (rt. temporo-occipital) 4319 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from 4/29, 1969, to 5/6, 1969, that (I) (we) last saw the deceased alive on 5/6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Joseph F. Schanno DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. PHYSICIAN'S NAME (Type) JOSEPH F. SCHANNO 22e. ADDRESS 8218 Shuman Ave. Bethesda																22c. DATE SIGNED 5/6/69	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)							
Burial		5-8-69		Parklawn Cemetery		Rockville, Maryland											
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland 25a. REC'D BY REGISTRAR MAY 12 1969 25b. REGISTRAR'S SIGNATURE Charles Judge																	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

83203

STATE OF TEXAS

( )

James T. ...

James T. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07204		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07200	
1. DECEASED-NAME (Type or print)			First	Middle	Last
Elizabeth			Ann	Rinker	
2a. DATE OF DEATH		Month		Day	Year
May		15		1969	
2b. HOUR		AM		8:10 M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS
Female	White	10 May 1945		24 YRS.	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland	U.S.A.			Montgomery Md.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center, NIH		Housewife		Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	
Maryland	Prince Georges	Greenbelt	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7 L Research Road	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Last	
William	Seibel	Virginia	Medley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 213-42-5487		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Myelogenous Leukemia/ in blastic crisis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2051</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-10 hours 3 1/2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Probable Hepatitis</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (X) (this hospital) attended the deceased from 22 February, 1969, to 15 May, 1969, that (X) (we) lost the deceased alive on 15 May, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>David A. Bray MD</u>		DEGREE ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 15 May 1969	
22d. PHYSICIAN'S NAME (Type) David A. Bray, MD		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/18/69	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md	
24. FUNERAL DIRECTOR Danaedean Funeral Home, Laurel, Md		25a. REC'D BY REGISTRAR DATE MAY 22 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07205		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07201			
1. DECEASED-NAME (Type or print) First Middle Last						2a. DATE OF DEATH Month Day Year		2b. HOUR	
Hedwig G. Roberts						May 6 1969		6:20 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		9-21-188		80 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md		Mont.		Rockville				Bethany Home 199 Rollins Ave	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last							
John Batchler		Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				Son - Daniel W. Roberts		Arlington, Va 717-North Edison St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) rupt. abdominal aortic aneurysm								1 hr.	
4412 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis								15 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (U) (this hospital) attended the deceased from Feb 1969, to 6 May 1969, that (U) (we) last saw the deceased alive on 5 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
John W. Simmons		5-6-69		John W. Simmons					
22e. ADDRESS		22f. ADDRESS							
7801 Norfolk Ave., Bethesda, Md.		7801 Norfolk Ave., Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5-8-69		Cedar Hill Cemetery		Suitland, Md			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Simmons Bros		MAY 8 1969		J. J. J. J.					
25c. ADDRESS Wash. DC									
25d. ADDRESS Wash. DC									
25e. ADDRESS Wash. DC									
25f. ADDRESS Wash. DC									
25g. ADDRESS Wash. DC									
25h. ADDRESS Wash. DC									
25i. ADDRESS Wash. DC									
25j. ADDRESS Wash. DC									
25k. ADDRESS Wash. DC									
25l. ADDRESS Wash. DC									
25m. ADDRESS Wash. DC									
25n. ADDRESS Wash. DC									
25o. ADDRESS Wash. DC									
25p. ADDRESS Wash. DC									
25q. ADDRESS Wash. DC									
25r. ADDRESS Wash. DC									
25s. ADDRESS Wash. DC									
25t. ADDRESS Wash. DC									
25u. ADDRESS Wash. DC									
25v. ADDRESS Wash. DC									
25w. ADDRESS Wash. DC									
25x. ADDRESS Wash. DC									
25y. ADDRESS Wash. DC									
25z. ADDRESS Wash. DC									



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. (Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.)

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 412 MARYLAND STATE DEPARTMENT OF HEALTH  
5-22-69 ans DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07206

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07202

1. DECEASED-NAME (Type or Print) <u>Waller</u> <sup>First</sup> <u>Waller</u> <sup>Middle</sup> <u>Louis</u> <sup>Last</sup> <u>Roberts</u>		2a. DATE KNOWN OF DEATH <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> Month <u>5</u> Day <u>2</u> Year <u>69</u>		2b. HOUR <u>10:55A</u>
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>Mar. 1, 1916</u> <sup>53</sup> YRS.	6. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR MONTHS <u>      </u> DAYS <u>      </u>
7a. BIRTHPLACE (State or foreign country) <u>Va.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Montgomery</u>
10. CITY OR TOWN OF DEATH <u>Takoma Pk</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>7701 Eastern Ave #204</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>	13c. CITY OR TOWN <u>Takoma Pk</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <u>John</u> Middle <u>Roberts</u> Last <u>Watson</u>		15. MOTHER'S MAIDEN NAME First <u>Beulah</u> Middle <u>Watson</u> Last <u>Watson</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16b. SOCIAL SECURITY NO. <u>WW 11 578-20-8399</u>		17. INFORMANT <u>Pearl Selba (Sister)</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia, right lung</u> <u>571.9</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Fatty liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>      </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>19</u> P.M. <u>      </u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>MAY 2, 1969</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 5, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Springhill Baptist</u>
24. FUNERAL DIRECTOR <u>Everly-Wheatley</u>		23d. LOCATION (City or Town) (County) (State) <u>Ruckersville, Va.</u>		23e. REC'D BY REGISTRAR <u>May 7 1969</u>
23f. ADDRESS <u>1500 W. Braddock Alexandria, Va.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

07206

MEDICAL EXAMINATION REPORT

PATIENT NAME		DATE	
SEX		AGE	
RACE		RELIGION	
MARITAL STATUS		OCCUPATION	
EDUCATION		MILITARY SERVICE	
PREVIOUS ILLNESSES		CURRENT ILLNESSES	
ALLERGIES		MEDICATIONS	
PHYSICAL EXAMINATION		LABORATORY TESTS	
VITAL SIGNS		DIAGNOSIS	
TREATMENT		PROGNOSIS	
FOLLOW-UP		REMARKS	

Handwritten notes and signatures in the bottom right corner of the form.

## CERTIFICATE OF DEATH

07207

1. DECEASED NAME (Type or print) <b>Jennie Robinson</b>		2a. DATE OF DEATH 5 Month 9 Day '69		2b. HOUR 9:55 AM
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH 10-20-75		6. AGE (In years last birthday) 93 YRS.
7a. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Montgomery Valley Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>Domestic</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Dist. of Columbia Wash.</b>		13b. COUNTY <b>Wash.</b>	13c. CITY OR TOWN <b>Wash.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME <b>CHARLES BUCHANAN</b>		15. MOTHER'S MAIDEN NAME <b>Isaiah Robinson-son</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>4119</b>		17. INFORMANT <b>Isaiah Robinson-son</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Thromboembolism</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>15 YRS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Thromboembolism</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <b>4/21/69</b> to <b>5/9/69</b> , that (I) (we) saw the deceased alive on <b>5/7/69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Henry C. Seeger MD</b>		22c. DATE SIGNED <b>5/9/69</b>		22d. PHYSICIAN'S NAME (Type) <b>Henry C. Seeger MD</b>
23a. BURIAL, CREMATION, etc. <b>Buried</b>		23b. DATE <b>5/14/1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony MEM CEM</b>
23d. LOCATION (City or Town) <b>Landover</b>		(County) <b>Md</b>		(State)
24. FUNERAL DIRECTOR <b>William Spangler</b>		25a. REC'D BY REGISTRAR <b>May 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and destroy pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07207

TO DIRECTOR OF STATE

THE SECRETARY OF THE ARMY

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07208

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07204

1. DECEASED-NAME (Type or Print) <b>LULA MAY ROYSTON</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>5</b> - <b>17</b> Year <b>1969</b>			2b. HOUR <b>2:30 PM</b>
3. SEX <b>Fe</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH <b>8/12/85</b>	6. AGE (In years) <b>83</b> YRS.	IF UNDER 1 YEAR MONTHS <b>5</b> DAYS <b>17</b>	IF UNDER 24 HRS HOURS <b>2</b> MIN. <b>30</b>	2c. DATE PRONOUNCED DEAD Month <b>5</b> - <b>17</b> - Year <b>1969</b>
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.
10. CITY OR TOWN OF DEATH <b>Burtonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3929 Sandy Spring Rd.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Burtonsville</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
13e. STREET AND NUMBER <b>3929 SANDY SPRING RD.</b>		14. FATHER'S NAME First <b>James</b> Middle <b>Rayton</b> Last <b>Rayton</b>		15. MOTHER'S MAIDEN NAME First <b>Ellen</b> Middle <b>Libbert</b> Last <b>Libbert</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>4123</b>		17. INFORMANT <b>Mrs Louise Reed - above</b>		ADDRESS <b>- above</b>
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Arteriosclerotic Heart Disease</b> (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4123</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b></b>						
19a. DATE OF OPERATION <b></b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b></b>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b></b>		21b. TIME OF INJURY Month, Day, Year <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b></b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b></b>		21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <b>Belden R. Reap</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>MAY 17, 1969</b>		
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/20/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Detweiler Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Calmar Manor Md</b>
24. FUNERAL DIRECTOR <b>Canadrian Funeral Home, Laurel</b>		ADDRESS <b></b>		25a. REC'D BY REGISTRAR <b>MAY 22 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-371000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

CLASSIFICATION: [Illegible]

EXTENSION: [Illegible]

REMARKS: [Illegible]

ADMINISTRATIVE: [Illegible]

APPROVAL: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

REMARKS: [Illegible]

ADMINISTRATIVE: [Illegible]

APPROVAL: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

REMARKS: [Illegible]

ADMINISTRATIVE: [Illegible]

2509  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07205 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07205									
Items 5&7 Film 413 6/11/69 kk CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Emma A. Ruebsam			2a. DATE OF DEATH Month Day Year 5 31 69			2b. HOUR M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 8/20/1887 Unknown		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Canada		7b. CITIZEN OF WHAT COUNTRY? Unknown USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md.			
10. CITY OR TOWN OF DEATH Bethesda Kensington		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Hall Nursing		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Wash. DC		13b. COUNTY N		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME First Middle Last Samuel Wegenast		15. MOTHER'S MAIDEN NAME First Middle Last Martha Bowman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (a, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Sister 5415 Conn Ave., N.W., Wash, D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 20 yrs. 20 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>63</u> , to <u>30 May</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>29 May</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John H. Wynman</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 5-31-69	
22d. PHYSICIAN'S NAME (Type) JOHN H WYMAN					22e. ADDRESS 7601 NORFOLK AVE. Bethesda, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/31/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, P.G. Co., Md.			
24. FUNERAL DIRECTOR ADDRESS R.A. Pumphrey 7557 Wisc. Ave., Bethesda, Md					25a. REC'D BY REGISTRAR DATE JUN 5 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

CONFIDENTIAL



CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07210									
07206									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
GRACE			Campbell Russell			Month Day Year 5 5 69			6 50 A M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
FEMALE		CAU.		9/9/88			80 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
ENGLAND		U.S.A.				MONTGOMERY			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA			GROSVENOR LANE NURSING & CONVALESCENT CENTER			HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
D. C.			DISTRICT OF COLUMBIA		WASHINGTON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2200 - 19th ST N.W.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William C. LIDSTONE			SELEMA AUGUSTA CAMPBELL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			220-44-8242		Son William Russell		Same as Item 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH CAUSED BY:									
IMMEDIATE CAUSE (a) Intestinal obstruction									
2303 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tumor of intestinal tract.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 5/3, 1969, to present, that (I) (we) last saw the deceased alive on 5/4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John B. Umhoefer MD					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/5/69		
22d. PHYSICIAN'S NAME (Type) JOHN B. UMHOUER					22e. ADDRESS 8805 Conn. Ave. Chevy Chase MD				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5-8-69		Congressional Cem.		Washington, D. C.			
24. FUNERAL DIRECTOR ADDRESS Robert A. Pumphrey, Bethesda, Maryland					25a. REC'D BY REGISTRAR DATE MAY 7 1969		25b. REGISTRAR'S SIGNATURE		

